SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Mercy Health Plans

Product Name: PHIARCONVCOC (08)	SERFF Tr Num: MHPL-125742797	State: ArkansasLH
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed	State Tr Num: 39777
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Author: Suzanne McGinnis	Disposition Date: 09/17/2008
	Date Submitted: 07/28/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 09/17/2008	
State Status Changed: 09/17/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

See attached cover letter.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Suzanne McGinnis, Contract Specialist
Mercy Health Plans
Chesterfield, MO 63017

Suzanne.McGinnis@Mercy.net
(314) 214-8263 [Phone]
(314) 214-8103[FAX]

Filing Company Information

Mercy Health Plans	CoCode: 11529	State of Domicile: Missouri
14528 South Outer Forty Rd.	Group Code:	Company Type: LAH/PPO
Suite 300		
Chesterfield, MO 63017	Group Name:	State ID Number:
(314) 214-8100 ext. [Phone]	FEIN Number: 48-1262342	

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
0000096866	$50.00	07/21/2008

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/17/2008	09/17/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	08/26/2008	08/26/2008	Suzanne McGinnis	09/04/2008	09/04/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Conversion Policy	Form	Suzanne McGinnis	09/16/2008	09/16/2008
Redlined Document	Supporting Document	Suzanne McGinnis	09/16/2008	09/16/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
AR Conversion Filing	Note To Reviewer	Suzanne McGinnis	08/18/2008	08/18/2008

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 09/17/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Redlined documents	Approved-Closed	Yes
Supporting Document	Redlined Document	Approved-Closed	Yes
Form *(revised)*	Conversion Policy	Approved-Closed	Yes
Form *(revised)*	Conversion Policy	Approved-Closed	Yes
Form	Conversion Policy	Withdrawn	Yes
Form *(revised)*	Schedule of Coverage	Approved-Closed	Yes
Form	Schedule of Coverage	Withdrawn	Yes
Form	TMJ Rider	Approved-Closed	Yes

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/26/2008
Submitted Date	08/26/2008
Respond By Date	

Dear Suzanne McGinnis,

This will acknowledge receipt of the captioned filing.

Objection 1

- Conversion Policy (Form)

Comment: Please refer to Page 5, Who is Not Eligible t Enroll?. This section of the contract is not in compliance with ACA 23-86-115(c)(1). An individual may covert to a conversion policy and remain covered by that policy until all preexisting conditions are covered or would be covered under another group policy or contract.

Objection 2

- Conversion Policy (Form)

Comment: Please refer to Page 7, You are No Longer Eligible for Coverage. It is stated that you are no longer covered when you turn age 65 or become eligible for Medicare, or are covered by a similar health insurance plan. Please restate to read as follows: ....or has full coverage under a similar health insurance plan. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

Refer to ACA 23-86-115(c)(1)(B) & ACA 23-86-115(c)(2).

Objection 3

- Conversion Policy (Form)

Comment: Under the events outlined on Page 8, please remove the following: Death of Subscriber (See Rule 32, Section 20, Conversion privilege allowed).

Objection 4

- Conversion Policy (Form)

Comment: As outlined on Page 27, Maternity Services is a covered benefit. When maternity is a covered benefit, In-Vitro must also be covered. Refer to ACA 23-85-137, 23-86-118 and Rule 1.

Objection 5

- Conversion Policy (Form)

Comment: Page 33 outlines an exlusion for Chiropractic. Please refer to Opinion 2001-251. If services rendered could also be rendered by a doctor, the law requires the insurance company to cover such service. Also refer to ACA 23-79-114(a)(1).

Objection 6

- Conversion Policy (Form)

Comment: The certificate contains a Pre-Existing Condition exclusion that states...."Benefits for the treatment of a Preexisting Condition are excluded until the date You have been covered under this Policy for a period of twelve (12) months....". This provision is not in compliance with ACA 23-86-115(b)(2) or Rule 32, Section 13.

Objection 7

- Conversion Policy (Form)

Comment: The definition of Pregnancy contains language on Complications of Pregnancy. Since a Complication of Pregnancy is a benefit which is covered regardless of whether or not the policy covers benefits for a pregnancy, we request that you define Complications of Pregnancy separate from Pregnancy. Please refer to Rule 19, Section 5 C.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/04/2008
Submitted Date	09/04/2008

Dear Rosalind Minor,

Comments:
As requested, we have made the following revisions as noted below.

Response 1

Comments: Response to Objection #4:

We have included In-Vitro Fertilization as a standard benefit since Maternity is a covered benefit.

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Related Objection 1

Applies To:

- Conversion Policy (Form)

Comment:

As outlined on Page 27, Maternity Services is a covered benefit. When maternity is a covered benefit, In-Vitro must also be covered. Refer to ACA 23-85-137, 23-86-118 and Rule 1.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Redlined documents

Comment: See attached redlined documents

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: Response to Objection #6:

We have removed the Preexisting Condition exclusion.

Related Objection 1

Applies To:

- Conversion Policy (Form)

Comment:

The certificate contains a Pre-Existing Condition exclusion that states...."Benefits for the treatment of a Preexisting Condition are excluded until the date You have been covered under this Policy for a period of twelve (12) months....". This provision is not in compliance with ACA 23-86-115(b)(2) or Rule 32, Section 13.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments: Response to Objection #5:

We have removed the limitations that were applied to the Chiropractic benefit since these limitations/exclusions were not being applied to any one specific group.

Related Objection 1

Applies To:

- Conversion Policy (Form)

Comment:

Page 33 outlines an exlusion for Chiropractic. Please refer to Opinion 2001-251. If services rendered could also be rendered by a doctor, the law requires the insurance company to cover such service. Also refer to ACA 23-79-114(a)(1).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments: Response to Objection #3:

Rule 32, Section 20, Conversion privilege allowed, refers solely to group policies and does not apply to Individual Conversion plans; therefore, we respectfully disagree with this objection.

Related Objection 1

Applies To:

- Conversion Policy (Form)

Comment:

Under the events outlined on Page 8, please remove the following: Death of Subscriber (See Rule 32, Section 20, Conversion privilege allowed).

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments: Response to Objection #7:

Per your request, I have separated the definitions of Pregnancy and Complications of Pregnancy in compliance with Rule 19, Section 5C.

Related Objection 1

Applies To:

- Conversion Policy (Form)

Comment:

The definition of Pregnancy contains language on Complications of Pregnancy. Since a Complication of Pregnancy is a benefit which is covered regardless of whether or not the policy covers benefits for a pregnancy, we request that you define Complications of Pregnancy separate from Pregnancy. Please refer to Rule 19, Section 5 C.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 6

Comments: Response to Objection #1:

As requested, we have inserted an additional bullet to the Who is Eligible for Coverage section as follows, "An individual may convert to a conversion policy and remain covered by that policy until all preexisting conditions are covered or

would be covered under another group policy or contract".

Related Objection 1

Applies To:

- Conversion Policy (Form)

Comment:

Please refer to Page 5, Who is Not Eligible t Enroll?. This section of the contract is not in compliance with ACA 23-86-115(c)(1). An individual may covert to a conversion policy and remain covered by that policy until all preexisting conditions are covered or would be covered under another group policy or contract.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Conversion Policy	PHIARCONV (08)		Policy/Contract/Fraternal Certificate	Initial			AR Conversion COC (08) .pdf
Previous Version							
Conversion Policy	*PHIARCONV (08)*		*Policy/Contract/Fraternal Certificate*	*Initial*			AR Conversion_COC_FINAL 07.18.08.pdf
Schedule of Coverage	PHIARCONVSCH (08)		Schedule Pages	Initial			AR Conversion Schedule (08).pdf
Previous Version							

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Schedule of Coverage	*PHIARCO NVSCH (08)*	*Schedule Pages*	*Initial*	AR Conversion Schedule_07.22.08.pdf

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

No Rate/Rule Schedule items changed.

Response 7

Comments: Response to Objection #2:

We have edited the following paragraph in this section to read, "When You turn age 65 or become eligible for Medicare, or have full coverage by a similar health insurance plan (group or individual) which provides benefits for all preexisting conditions, or are eligible for similar benefits provided by state or federal laws, You are no longer eligible for this conversion coverage".

Related Objection 1

Applies To:

- Conversion Policy (Form)

Comment:

Please refer to Page 7, You are No Longer Eligible for Coverage. It is stated that you are no longer covered when you turn age 65 or become eligible for Medicare, or are covered by a similar health insurance plan. Please restate to read as follows: ....or has full coverage under a similar health insurance plan. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

Refer to ACA 23-86-115(c)(1)(B) & ACA 23-86-115(c)(2).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We have also made additional changes to both the COC and Schedule of Coverage. These changes are indicated in the supporting redlined documents. We believe all sections noted above should now be in compliance and we look forward to your approval.

Sincerely,
Suzanne McGinnis

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Amendment Letter

Amendment Date:
Submitted Date: 09/16/2008

Comments:

Dear Rosalind,

Per our telephone conversation of 9/15/08, we have revised our Certificate of Coverage to comply with Rule 32, Section 20, Conversion privilege allowed, by removing Death of Subscriber and corrected any references stated in Section 4 (When Coverage Ends).

Thank you.

Sue McGinnis

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
PHIARCONV (08)	Policy/Contract/Fraternal Certificate	Conversion Policy	Initial					AR Conversion COC (08) .pdf

Supporting Document Schedule Item Changes:

User Added -Name: Redlined Document

Comment:

AR Conversion COC_Redlined_8,9.pdf

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:
Suzanne McGinnis on 08/18/2008 04:09 PM
Subject:
AR Conversion Filing
Comments:
Rosalind,

I logged into SERFF today, 8/18/08, to check the status of this filing and noticed that the State Status field shows "Pending Fees". A check for the filing fee of $50.00 was shipped express overnight on 7/28/08 and delivered to your office address on 7/29/08. Could you please advise of the status? We have a group wanting this Conversion product.

Thanks very much.

Sue McGinninis
Mercy Health Plans
Contract Specialist
314-214-8263

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	PHIARCONV (08)	Policy/Contract/Fraternal Certificate	Conversion Policy	Initial			AR Conversion COC (08) .pdf
Approved-Closed	PHIARCONV (08)	Policy/Contract/Fraternal Certificate	Conversion Policy	Initial			AR Conversion COC (08) .pdf
Approved-Closed	PHIARCONVSCH (08)	Schedule Pages	Schedule of Coverage	Initial			AR Conversion Schedule (08).pdf
Approved-Closed	PHIARCONV/TMJ (08)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	TMJ Rider	Initial			AR CONV TMJ Rider_7.21.08 .pdf

Your Individual Conversion Policy

Issued by: Mercy Health Plans

This Individual Conversion Policy is guaranteed renewable

NOTICE:

The Benefits in this Policy do not necessarily equal or match those Benefits provided in Your previous group Policy

This Health Plan is underwritten by Mercy Health Plans. The Benefits and main points of coverage under the Plan are set forth in this Individual Conversion Policy and Schedule of Coverage and Benefits and any attached Riders. The Benefits are effective only while You are covered by this conversion Policy. The Benefits in this Policy do not necessarily equal or match those benefits provided in your previous group Policy.

This Policy describes the Benefits for health care services provided by Mercy Health Plans and the extent to which Benefit Payment may be limited. The Policy may be terminated by Mercy Health Plans or by You as described in this Policy.

You may return this Policy within ten (10) days of its receipt for full refund of any Premiums paid if, after examining it, You are not satisfied for any reason. Written notification is required to return this Policy. If services are utilized during this (10) day period, this policy is assumed to be accepted. Any coverage returned for a refund of premium will be null and void from its inception.

Mercy Health Plans
14528 S Outer 40, Suite 300
Chesterfield, Missouri 63017
314-214-8100
800-830-1918
www.mercyhealthplans.com

Table of Contents

Individual Health Conversion Policy

The Individual Health Conversion Policy is a legal document between **Mercy Health Plans** (**"The Plan", "We", "Us", "Our"**) and **the Enrolling Individual** (**"You", "Your"**) to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrollee's application and payment of the required Policy premium within thirty (30) days after termination from Your group health policy.

The Policy includes:

- The Enrollee's application;
- Any Amendments and Riders;
- The Schedule of Coverage and Benefits and any inserts to the Conversion Policy.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens We will send You the revised Policy, Rider or Amendment pages.

No one has the authority to make any changes to the Policy unless those changes are in writing and signed by an officer of Mercy Health Plans. No change shall be valid until approved and made part of the Policy. Only the Plan has the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without Your approval.

Information You Should Have

This Policy describes Benefits in effect as of Effective Date of Policy Issuance.

On its Effective Date, this Policy replaces and overrules any Policy that We may have previously issued to You, or Your employer. This Policy will in turn be overruled by any Policy We issue to You in the future.

Coverage under the Policy will begin at 12:01 a.m. on the Effective Date and end at 12:00 midnight on the Termination Date. The Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to termination of the Policy.

This Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

We are delivering the Policy in the State of Arkansas. The laws of the State of Arkansas govern this Policy.

The validity of the Policy will not be contested after the Policy has been in force for three (3) years from the date of issue. No statement relating to insurability, made by any person covered under the Policy, will be used to contest the validity of the Policy after it has been in force for a period of three (3) years. In addition, the statement must be contained in a written instrument signed by the person making the statement. The assertion, at any time, of defenses based upon the person's ineligibility for coverage under the Policy, or upon other provisions in the Policy, will not be precluded.

Section 1: Introduction to Your Policy

We encourage You to read Your Policy and any attached Riders and/or Amendments carefully.

Information about Defined Terms

Because this Policy is part of a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in Section 13 (Definitions of Terms). You can refer to Section 13 as You read this document to have a clearer understanding of Your Policy of Coverage.

When We use the words **"The Plan"**, **"We", "Us", and "Our"** in this document, We are referring to **Mercy Health Plans.** When We use the words **"You" and "Your",** We are referring to people who are **Covered Persons** as the term is defined in Section 13 (Definitions of Terms).

This Policy and the other Policy documents describe Your Benefits as well as Your rights and responsibilities under the Policy.

We especially encourage You to review the Benefit limitations of this Policy by reading Section 11 (Covered Benefits) and Section 12 (Exclusions). You should also carefully read Section 10 (General Provisions) to better understand how this Policy and Your Benefits work. You should call Us if You have questions about the coverage available to You.

Many of the Sections of the Policy are related to other Sections of the document. You may not have all of the information You need by reading just one Section. We also encourage You to keep Your Policy and any attachments in a safe place for Your future reference.

Please be aware that Your Physician does not have a copy of Your Policy of Coverage, and is not responsible for knowing or communicating Your Benefits.

Required Premiums, Premium Changes and Grace Period

The Plan requires payment of Premiums by the 15th of each month for this Policy. You must pay the required premium within a 31-day grace period to keep this Policy in force. All premiums must be paid via any one of the following methods:

- ACH Direct Debit Program
- Credit Card payment
- A check for the entire annual Premium

Your Conversion Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

Upon the payment of a claim under this Policy, any Premium then due and unpaid or covered by any note or written order may be deducted from the claim payment. We may change the amount of Your Premiums on any monthly due date upon giving You sixty (60) days prior written notice.

We may change the terms and conditions of this Policy to conform to the laws of the State of Arkansas, to conform to Federal law or to conform to underwriting policies established by Mercy Health Plans, after submission to and approval by the Arkansas Insurance Department. For changes in terms and conditions, We must give written notice thirty (30) days before the change. This notice may be in the form of a new Policy, or a Rider or Amendment to this Policy.

Don't Hesitate to Contact Us

Throughout the document You will find statements that encourage You to contact Us for further information. Whenever You have a question or concern regarding Your Benefits, please call Us using the telephone number for Our Customer Contact Center listed on Your ID card.

Section 2: Eligibility

How to Enroll

If Eligible, the Enrolling Individual must complete an enrollment application and submit the properly completed form to Us, along with any required Premium within thirty (30) days after termination of Your group health policy. We will not provide Benefits for health services that You receive before Your Effective Date of coverage.

If You Are Hospitalized When Your Coverage Begins

If You are a patient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the effective date of this Policy, We will pay Benefits for Covered Health Services related to that Inpatient Stay as long as You receive Covered Health Services in accordance with the terms of the Policy.

If You are hospitalized when Your coverage begins, You should notify Us within forty-eight (48) hours of Your effective date, or as soon as is reasonably possible. Network Benefits are available only if You receive Covered Health Services from Network Providers.

Who is Eligible for Coverage?

To be eligible for this coverage, Your primary domicile must be within Arkansas.

A converted policy need not be made available if termination occurred for any of the following reasons:

- You failed to make timely payment of any required contribution.
- The Group Policy terminated or a group's participation terminated, and the insurance is replaced by similar coverage under another Group Policy within thirty-one (31) days of the date of termination.
- An individual may convert to a conversion policy and remain covered by that policy until all preexisting conditions are covered or would be covered under another group policy or contract.

Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under your group Policy.

The converted policy shall cover the employee or Member and his/her Dependents who were covered by the Group Policy on the date of termination of insurance.

Who is Not Eligible to Enroll?

We are not required to issue a converted policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted policy covering any person if:

- Such person is or could be covered for similar benefits by another individual policy;
- Such person is or could be covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured, or similar benefits are provided for or available to such person, by reasons of state or Federal law; and
- The benefits under sources of the kind referred to above for such person, or benefits provided or available under sources of the kind referred to above for such person, together with the converted policy's benefits would result in over-insurance according to the insurer's standards for over-insurance.

Persons not eligible for coverage include –

a) Those whose coverage was previously terminated for the following causes:
    - Fraud or misrepresentation in the application;
    - Abuse of services or facilities;
    - Improper use of ID Card;
    - Misconduct detrimental to Plan operations and the delivery of services;
    - Failure to pay Premiums more than twice in the past 12 months, or to pay Premiums in a timely manner in accordance with the terms of the Policy.

Refer to Section 4 (When Coverage Ends) for a detailed description of these causes that lead to termination.

Section 3: When Coverage Begins

Initial Enrollment Period

The Initial Enrollment Period is the first time You enroll Yourself and/Your eligible Dependents, subject to acceptance by the Plan. Coverage begins on the Effective Date as determined by the Plan and when We approve Your completed application and receive any required Premium. Only a Subscriber or Dependent that was covered under the group Policy this conversion Policy replaces on the date of termination of such group Policy are Eligible to enroll in this Policy.

Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is Totally Disabled because of a mental or a physical disability will not end just because the child has reached a certain age. We will extend the coverage for the disabled child beyond the limiting age if both of the following are true:

- The disabled child is not able to be self-supporting because of a mental or physical disability; **and**
- The disabled child depends primarily on the Subscriber for support and maintenance due to the mental or physical disability.

Coverage will continue as long as the Enrolled Dependent is disabled and continues to satisfy both of these qualifying conditions, unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask You to furnish Us with proof of the disabled child's incapacity and dependency within a reasonable time after the date coverage would otherwise have ended because the child reached a certain age. Before We agree to this extension of coverage for the child, We may require that a Physician chosen by Us examine the child. We will pay for that examination.

We may continue to ask You for proof that the disabled child still meets these two conditions, but will not ask more than once per year. The proof We ask for might include medical examinations at Our expense.

If You do not provide proof acceptable to Us of the disabled child's incapacity and dependency, as described above, coverage for that child will end.

Section 4: When Coverage Ends

General Information about When Coverage Ends:

- We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.
- Your entitlement to Benefits automatically ends on the date that coverage ends, even if You are hospitalized or are otherwise receiving medical treatment on that date.
- When Your coverage ends, We will still pay claims for Covered Health Services that You received before Your coverage ended. However, once Your coverage ends, We do not provide Benefits for health services that You receive for medical conditions that occurred after Your coverage ended.
- An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends except in the event of the Subscriber's death.

Events Ending Your Coverage

Your coverage ends on the earliest of the dates specified in the following outline:

Event	Description
The Entire Individual Policy Ends	Your coverage ends on the date the Individual Policy ends. The Plan is responsible for notifying You that Your coverage has ended.
You Are No Longer Eligible for Coverage	Your coverage ends on the date You are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 2 (Eligibility) and Section 13 (Definitions of Terms) for more information. **When You turn age 65 or become eligible for Medicare, or have full coverage by a similar health insurance plan (group or individual) which provides benefits for all preexisting conditions, or are eligible for similar benefits provided by state or federal laws, You are no longer eligible for this conversion coverage.** If Your coverage ends due to Your death and We receive notification within one (1) year of Your death, Premiums paid for coverage beyond the date of Your death will be refunded to You or Your estate within thirty (30) days after We receive written proof of Your death. In the event of the Subscriber's death, and upon notification to the Plan, coverage may continue for Eligible Spouse and/or Dependents who were covered by the Group Policy on the date of termination of insurance.
We Receive Notice to End Coverage	Your coverage ends at the end of the month that We receive Your request in writing. We must receive Your termination notice **prior** to Your requested date of termination. Your Conversion Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period.
Fraud, Misrepresentation or False Information	Your coverage ends on the date We identify, in a notice, that Your coverage is terminated because of fraud or misrepresentation. We will provide written notice to the Subscriber that coverage has ended. During the first three (3) years the Policy is in effect, if You provided Us with false information or misrepresentation of material facts regarding Your application or coverage, We have the right to demand that You pay back all Benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under the Policy. After the first three (3) years, We can only demand that You pay back these Benefits if the written application contained a fraudulent misstatement.

Event	Description
Abuse of Services or Facilities	In the event of abuse by a Covered Person in the use of services or facilities, that person's coverage may be restricted or canceled by the Plan upon at least thirty-one (31) days' prior written notice to the Member.
Improper Use of ID Card	Your coverage ends when You permit an unauthorized person to use Your ID card, or You used another person's card. When Your coverage is terminated because of improper use of Your ID card, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice.
Misconduct	In the event Your misconduct is detrimental to the safe Plan operations and the delivery of services, Your coverage may be cancelled immediately.
Moving Out of State	Coverage will end within sixty (60) days after We receive notice of Your move out of Arkansas.
Non-Payment of Premiums	This Policy will automatically end on the last day of the period for which Premiums have been paid. If Premiums are not paid within the grace period, thirty-one (31) days from the premium due date, there will be no reinstatement.

Section 5: How You Get Care

Identification cards

We will send You an identification (ID) card when You enroll. You should carry Your ID card with You at all times. You must show it whenever You receive services from a Network Provider. If You do not show Your ID card, Network Providers have no way of knowing that You are enrolled under Our Conversion Policy. As a result, they may bill You for the entire cost of the services You receive.

If You do not receive Your ID card within thirty (30) days after the Effective Date of Your enrollment, or if You need replacement cards, call Us at 866-647-5568. You must show Your ID card every time You request Health Care Services from a Network Provider.

Where You get covered care

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Individual Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 4 (When Coverage Ends) occurs.
- The person who received Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

You will only pay Copayments, Deductibles, and/or Coinsurances when receiving care from a Network Provider for a Covered Health Service. If You use Non-Network Providers, it will cost You more.

Network Providers

Network Providers are Physicians and other health care professionals that We contract with to provide Covered Services to Our Members. Network Providers are independent practitioners. They are not Our employees. It is Your responsibility to select Your provider. We credential Network Providers according to national standards. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

A directory of Network Providers is available on our website at www.mercyhealthplans.com We update the provider directory periodically. However, before obtaining services You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Our Customer Contact Center at 866-647-5568.

It is possible that You might not be able to obtain services from a particular Network Provider. The Network of providers is subject to change. You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of Our products. Refer to Your provider directory or contact Us for assistance.

Extended Provider Network

Mercy Health Plans has an extended provider network **outside** of Our contracted network called Private Healthcare Systems Preferred Provider Organization (PHCS PPO). This extended Provider Network is available to You as Network Benefits only when you are **outside** of Our contracted network. To find a PHCS PPO provider, call Our Customer Contact Center or visit www.phcs.com and select the PPO Network.

PHCS PPO Network is not available when you receive services **within** Mercy Health Plans' contracted network.

Network Benefits

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services that are described as Network Benefits in Section 11 (Covered Benefits) and are any of the following:

- Provided by a Network Physician or other Network Provider.
- Emergency Room Services.

Designated Facilities and Other Providers

If You have a medical condition that We believe needs special services, We may direct You to a Designated Facility or other Network Provider chosen by Us. Network Benefits will only be paid if Your Covered Health Services for that condition are provided by, or arranged by the Network Designated Facility, or other Network Provider chosen by Us. Non-Network Benefits will apply to any Non-Network facility or provider.

Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by Non-Network Physicians or Non-Network Providers.

What You must do to get covered care

You or Your physician must notify Us and obtain Prior Authorization before getting certain Covered Health Services from either Network or Non-Network Providers. However, **You are responsible for ensuring that Your provider obtains any required Prior-Authorization before You receive Covered Health Services.** A current list of those services and supplies requiring Prior Authorization is available by calling Our Customer Contact Center at the telephone number listed on Your ID card, or by visiting www.mercyhealthplans.com. Verify with your Physician, or Our Contact Center, the authorized date range, and the number and type of services.

We urge You to confirm with Us that the services You plan to receive are Covered Health Services. Prior Authorization does not mean Benefits are payable in all cases. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before You receive treatment, You can check to see if the service is subject to limitations or exclusions including, but not limited to:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reconstruction; vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty;
- The Experimental, Investigational or Unproven Services exclusion;
- Any other contract limitation or exclusion.

FAILURE TO PREAUTHORIZE CERTAIN BENEFITS MAY RESULT IN A REDUCTION OF ELIGIBLE EXPENSES.

Care Management

When You notify Us as described above, We will work together to implement the care management process and to provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Room Services

We provide Benefits for Emergency Room Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Services, even if a Non-Network Provider provides the services. Emergency Services and any follow-up care rendered by a Non-Network Provider must be:

1. Of such immediate nature that Your health would be jeopardized if taken to a Network Hospital where the services of a Participating Physician would be available, or
2. Provided under circumstances under which You are unable, due to Your condition, to

request treatment at a location where the services of a Participating Physician would be available.

- If You are admitted as an inpatient to a Network or Non-Network Hospital after You receive Emergency Room Services, We must be notified within two (2) working days or on the same day of admission, or as soon as reasonably possible to receive authorization for continued services. Continuation of care as for any Inpatient Stay requires Prior Authorization and approval by the Plan.
- If You are admitted as an inpatient to a Non-Network Hospital after you receive Emergency Room Services, We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date We decide a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
- If You are admitted as an inpatient to a Network or Non-Network Hospital within twenty-four (24) hours of receiving treatment for the same condition as an Emergency Service, You will not have to pay the Copayment for Emergency Room Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

Urgent Care Services

Covered Health Services that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. Urgent Care is not the same as Emergency Care.

Section 6: Your Cost for Covered Services

This is what You will pay for covered care:

Copayments

A Copayment is a fixed amount of money You pay to the provider, facility, pharmacy, etc., when You receive *certain* services. **Copayments do not count towards Your Out-of-Pocket Maximum or Your Deductible.** Copayment amounts are listed on the Schedule of Coverage and Benefits next to the description for each Covered Health Service.

Coinsurance

Coinsurance is the percentage of Our Eligible Expenses that You must pay for Your care. Coinsurance doesn't begin until after You meet Your Deductible. **Only Coinsurances count toward Your Out-of-Pocket Maximum.**

Deductible

A Deductible is a fixed expense You must incur within a Calendar Yearfor certain Covered Services and supplies before We start paying Benefits for them. For a complete definition of Annual Deductible, see Section 13 (Definitions of Terms).

NOTE: The Network Deductible does not apply to the Non-Network Deductible; also, the Non-Network Deductible does not apply to the Network Deductible.

Deductibles do not apply to Your Out-of-Pocket Maximum.

For Your Annual Deductible see Your Schedule of Coverage and Benefits.

Eligible Expenses

Eligible Expenses are the amount We determine that We will pay for Benefits minus any Copayment, Coinsurance or Deductible. We will pay a contracted rate for Network Providers. For Non-Network Providers, however, We will pay the Usual and Customary Rate (UCR) as determined by Us. For a complete definition of Eligible Expenses and UCR that describes how We determine payment, see Section 13 (Definitions of Terms).

Charges in Excess of the UCR

Charges by a provider in excess of UCR will not be covered under this Policy and will not be counted toward Your Out-Of-Pocket Maximum limit or Deductible.

For Network Benefits, You are not responsible for any difference between the Eligible Expenses and the amount the provider bills, but You are responsible for all Copayments, Coinsurances or Deductibles.

For Non-Network Benefits, You are responsible to pay, directly to the Non-Network Provider, any difference between the amount the provider bills You and the UCR amount We will pay for Eligible Expenses. Please see Section 12 (Exclusions).

Out-of-Pocket Maximum

The maximum You pay out of Your pocket in a CalendarYear for Coinsurances. For a complete definition of Out-of-Pocket Maximum, see Section 13 (Definitions of Terms).

If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that CalendarYear. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that CalendarYear.

The Out-of-Pocket Maximum does not include any of the following:

- Any charges for Non-Covered Health Services;
- Copayments for Covered Health Services available by an optional Rider;
- The amount of any reduced Benefits if You don't obtain Prior Authorization as described in Section 11 (Covered Benefits);
- Charges that exceed Eligible Expenses;
- Any Copayments for Covered Health Services in Section 11 (Covered Benefits);
- The Annual Deductible.

For Your Annual Out-of-Pocket Maximum see Your Schedule of Coverage and Benefits.

Maximum Policy Benefit

The maximum amount We will pay for Benefits during the entire period of time You are enrolled under the Policy. For a complete definition of Maximum Policy Benefit, see Section 13 (Definitions of Terms).

For Your Maximum Policy Benefit see Your Schedule of Coverage and Benefits.

Section 7: How to File a Claim

Network Provider

We pay Network Providers directly for Your Covered Health Services, so Network Providers file claims on Your behalf to us. If a Network Provider bills You for any Covered Health Service, contact Us. However, You are responsible for meeting any Annual Deductible and paying Copayments or Coinsurance to a Network Provider at the time of service or when You receive a bill from the Provider.

Non-Network Provider

When You receive Covered Health Services from a Non-Network Provider, You may be responsible for paying for all expenses up front and then requesting reimbursement from Us.

How to File a Claim

While You do not need to fill out a specific claim form, You must file the claim in a format that contains all of the information We require, as described below.

If a Subscriber provides written authorization to a Non-Network Provider for payment of medical Benefits for any Eligible Expenses, reimbursement may be paid directly to that Provider. If the subscriber did not sign authorization for payment of medical Benefits, the subscriber may be responsible for paying all expenses up front and then requesting reimbursement from Us. We will not reimburse third parties who have purchased or been assigned Benefits by Physicians or other Providers.

Required Information for Claims

When You request payment of Benefits from Us, You must provide Us with all of the following information:

1. The Subscriber's name and address;
2. The patient's name and age;
3. The number stated on Your ID card;
4. The name, address, phone number and Tax ID of the provider of the service(s);
5. A diagnosis from the Physician;
6. An itemized bill from the provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge;
7. The date the Injury or Sickness began;
8. A statement indicating whether You are, or You are not, enrolled for coverage under any other health insurance plan or program. If You are enrolled for other coverage, You must include the name of the other carrier(s), the name and date of birth of the subscriber for that coverage and the effective date of the coverage..

Proof of Loss

Written proof of such loss and notice of claim must be provided to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within such time will neither invalidate nor reduce any claim, if it was not reasonably possible to furnish such proof within such time. In no event, except in the absence of legal capacity of the claimant, will a claim be valid later than one (1) year from the time proof is otherwise required. All Benefits payable under the Policy will be paid within thirty (30) days after receipt of proof. Written proofs of claim must be furnished to the Plan at P.O. Box 4568, Springfield, MO 65808.

Time of Payment of Claims

Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim. All eligible reimbursement will be payable to Providers. We will send You an Explanation of Benefits form or letter. This will show You what services were paid, how much was paid, who was paid, when payment was made, or why payment for some services was not made or was made in part. There may be some circumstances for which We must seek additional information from You to process the claim. We will suspend (pend) the claim for up to thirty (30) days to give You ample time to respond. If You fail to respond within the thirty (30) days, the claim will be denied. If You present the information after the thirty (30) days allocated, the claim will be reprocessed in accordance to the terms and Benefits of Your coverage. If We deny all or any part of Your claim, We will send You an Explanation of Benefits form or a letter telling You why it was denied. The form or letter may also tell You what other information, if any, We

would need to reconsider Our decision. If You do not agree with Our decision, You have the right to appeal Your claim. See Section 8 (Complaints, Grievances and Appeals). You may also call or write Us, or You may contact the Arkansas Insurance Department.

Action on Claims

If a claim is denied, We will send You a written notice that contains the reason for the denial and information on Your right to appeal. If You believe there is a discrepancy between the Benefits, the Policy, and the processing of such claim, or if You have a Grievance, You must notify the Plan no later than one-hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to a Grievance. If a claim is denied, You may obtain a review of the denial through the Complaint and Grievance Procedure. See Section 8 (Complaints, Grievances and Appeals).

Release of Records

During the processing of Your claim, We might need to review Your health records. As a Covered Person, You hereby authorize the release to Us of all health records related to Your claim. This release constitutes authorization of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality under the terms of applicable privacy laws. This authorization also applies to any Covered Dependent under this Policy.

Direct Payment to Public Hospitals

Benefits for Covered Health Services will be paid, with or without an assignment from You, to public hospitals or clinics for services and supplies provided to You, if proper claim is submitted by the public hospital or clinic. No Benefits will be paid under this Section to the public hospital or clinic, if such Benefits have been paid to You prior to Us receiving Your claim. Payment to the public hospital or clinic will discharge Us from all liability to You to the extent of the Benefits so paid.

Section 8: Complaints, Grievances & Appeals

These procedures address all Complaints, Grievances, and appeals from Members concerning operation of the Plan, **except** any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment.

A Member, a Member's authorized representative, or a Provider can make a Complaint or Grievance at any time. Complaints can be about anything, including: the Plan's service, Utilization Review, or a provider's service. A Complaint or Grievance can always be directed to the Arkansas Insurance Department at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
1-800-852-5494

Step	Description

1 **What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.**

Customer Contact Center Representatives are available to take Your call during regular business hours, 8:00 AM – 5:00 PM, Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below.

The Plan agrees to investigate, and endeavor to resolve, any and all Complaints received from Members with regard to the nature of professional services rendered, or Benefits provided, under thisPolicy. Oral complaints or inquiries can be made to the Plan by telephone or an arranged appointment with the Customer Contact Center Representative at:

Mercy Health Plans
ATTN: Customer Contact Center
14528 S. Outer 40, Suite 300
Chesterfield, Missouri 63017-5743
866-450-3249

The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your rightful access to review through the formal Grievance Process.

2 **Ask Us in writing to reconsider Our initial decision.**

Minimum Time to File a Grievance: You must file a Grievance no later than one hundred eighty (180) days from the date that written notice was sent from the Plan, informing You of the event that gave rise to the Grievance.

Grievance Procedure: Ask Us in writing to reconsider Our initial decision. You, Your authorized representative, or Your Provider can submit a Grievance described below.

a) Write to Us no later than one hundred eighty (180) days from the date that written notice was sent from the Plan to You, informing You of the event that gave rise to the Grievance;

b) Send Your request to: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743;

c) Include a statement about why You believe Our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms.

The Plan will acknowledge receipt of Your Grievance in writing within ten (10) working days. A complete investigation of the Grievance will follow. Someone who is neither the individual who made the initial determination, nor the subordinate of such individual will conduct the review.

In the case of a Grievance involving a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual.

We will notify You of Our determination in writing as follows:

- Within thirty (30) calendar days for a service You have not yet received pre-service; or
- Within sixty (60) calendar days for a service You have already received post-service.

This written determination will include information about Your right to request an External Independent Review (if We maintain Our denial of an Adverse Determination) and Your right to other voluntary alternative dispute resolution..

3 ***Expedited Grievance Procedure:*** When the standard time frames of the Grievance procedure would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) working days of the notification of the determination.

4 ***Ask Us for an External Independent Review, only if Your appeal was related to an Adverse Determination.***

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Review. A request for a standard External Review must be made in writing, and should include any information or documentation to support Your request for the covered service. **Note: Only appeals that are related to an Adverse Determination and that involve treatment, services, equipment, supplies, or drugs that would require the Plan to expend $500 or more of expenditures are afforded an External Independent Review.**

"Adverse Determination" means a determination by the Plan that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested health care service does not meet the Plan's requirements for medical necessity, or

(b) The requested health care service has been found to be "Experimental/Investigational."

The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the External Independent Review organization selected to perform the review. For the purposes of this Section, an External Independent Reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the case; and (c) have not been informed of the specific identity of the Member.

The independent review organization will complete its review within forty-five (45) calendar days after the receipt of the request for an External Review and will provide a written notice of its decision to You, or Your authorized representative, and the Plan.

An expedited External Independent Review may be requested for a situation when a delay would significantly increase the risk to Your health or when extended health care services for a course of treatment that You are undergoing is at issue. Upon submission of a request for expedited External Independent Review, the Plan will immediately assign an independent review organization approved by the Arkansas Insurance Department. The independent review organization shall make a determination and verbally notify You, or Your authorized representative, and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the independent reviewer is final. Within two (2) calendar days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

5 At any time, You have the right to contact the Arkansas Insurance Department 's consumer complaint hotline at: **1-800-852-5494** regarding Your grievance, or write to the Arkansas Insurance Department at the following address: **Arkansas Insurance Department, Consumer Services Division, Third and Cross Streets, Little Rock, AR 72201**.

Section 9: Utilization Review

The following is information pertaining to Utilization Review decisions and procedures. Please note that in addition to Utilization Reviews, Mercy Health Plans' practices Care Management, and therefore may provide You with information about additional services that are available to You such as disease management programs, health education, pre-admission counseling and patient advocacy.

Initial Determinations

For initial determinations, the Plan will make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this Section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an admission, procedure or service, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification.

In the case of an Adverse Determination, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the Adverse Determination; and will provide written or electronic confirmation of the telephone notification to You and Your provider within one (1) working day of making the Adverse Determination.

Concurrent Review Determinations

For concurrent review determinations, the Plan will make the determination within one (1) working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, the Plan will notify by telephone the provider rendering the service within one (1) working day of making the certification.

In the case of an Adverse Determination, the Plan will notify by telephone the provider rendering the services within twenty-four (24) hours of making the Adverse Determination, and provide written or electronic notification to You and Your provider within one (1) working day of the telephone notification.

Retrospective Review Determinations

For retrospective review determinations, the Plan will make the determination within thirty (30) working days of receiving all necessary information. The Plan will provide notice in writing of Our determination to You within ten (10) working days of making the determination.

Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. The Plan will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination, to any party who received notice of the Adverse Determination, and who requests such information.

Reconsideration of an Adverse Determination

In a case involving an initial determination or a concurrent review determination, the Plan will give the provider rendering the service an opportunity to request, on Your behalf, a reconsideration of an Adverse Determination by the reviewer making the Adverse Determination.

The reconsideration will occur within one (1) working day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the Adverse Determination, or a clinical peer designated by the reviewer who made the Adverse Determination (if the reviewer who made the Adverse Determination is not available within one (1) working day).

If the reconsideration process does not resolve the difference of opinion, You or Your provider may appeal the Adverse Determination. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an Adverse Determination.

Lack of Information

The Plan will have written procedures to address failure or inability of a provider or an enrollee to provide all necessary Information for review. In cases where the provider or an enrollee will not release necessary information, the Plan may deny certification of an admission, procedure or service.

Complaint and Grievance Procedures

These procedures address all Complaints, Grievances, and appeals concerning operation of Mercy Health Plans except any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment. The Complaint procedure is more fully described in Section 8 (Complaints, Grievances and Appeals).

Section 10: General Provisions

Your Relationship with Us

In order to make choices about Your health care coverage and treatment, We believe that it is important for You to understand how We interact with You. We help finance and administer the benefit plan in which You are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to You decisions about whether Your benefit plan will cover or pay for the health care that You may receive. The plan pays for certain medical costs, which are more fully described in this Policy. The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.
- We do not decide what care You need or will receive. You and Your Physician make those decisions.

We may use individually identifiable information about You to share with You (and You alone) procedures, products or services that You may find valuable. We will use individually identifiable information about You as permitted or required by law, in Our operations and in Our research. We will use de-identified data for commercial purposes, including research.

Our Relationship with You

The relationship between You and the Plan is solely a contractual relationship between independent contractors. You are not Our agent or employee. Neither We nor any of Our employees are Your agents.

We do not provide Health Care Services or supplies, nor do We practice medicine. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of Benefits under Your benefit plan.

You are solely responsible for all of the following:

- Enrollment changes (including the termination of Your coverage).
- The timely payment of the required Premium to Us.

Your Relationship with Providers

The relationship between You and any provider is that of provider and patient;

- You are responsible for choosing Your own provider;
- You must decide if any provider treating You is right for You. This includes providers You choose and providers to whom You have been referred;

- You must decide with Your provider what care You should receive;
- Your provider is solely responsible for the quality of the services provided to You.

Administrative Services

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Our sole discretion. We are not required to give You prior notice of any such change, nor are We required to obtain Your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, We reserve the right, in Our sole discretion and without Your approval, to change, interpret, modify, withdraw or add Benefits, or terminate the Policy.

Any provision of the Policy that on its Effective Date is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy, unless it is made by an Amendment or Rider that has been signed by one of Our officers. All of the following conditions apply:

- Amendments to the Policy are effective thirty-one (31) days after We send a written notice to the Enrolling Individual.
- Riders are effective on the date We specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Assignment

This Policy and all the rights, responsibilities and benefit payments under it are personal to You. You may assign them to any Provider of Covered Service.

Case Management

Case Management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family, and the attending physician to determine appropriate treatment options that will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation, or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to You or Your Dependent. In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive You of Benefits under the Policy, nor will it create a right to Benefits. If the Enrolling Individual makes a clerical error (including, but not limited to, sending Us inaccurate information regarding Your enrollment for coverage or the termination of Your coverage under the Policy) We will not make retroactive adjustments beyond a 60-day time period unless we are at fault. Our clerical errors or delays in keeping or reporting data relative to coverage will not terminate coverage which would otherwise be in force, nor continue coverage which would otherwise be terminated. Upon discovery of errors or delays, We will make whatever change is needed to assure that You have the coverage to which You are entitled to. No retroactive coverage or Premium changes will be made unless prior written approval is received from Us.

Conformity with State Laws

If any provision(s) of this Policy conflicts with Arkansas law, then those provision(s) are automatically changed to conform to at least the minimum requirements of the law.

Commission or Omission

No Hospital, Physician or other Provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other Providers or services or their agent or employee; or (4) You.

Entire Policy/Changes

The Policy issued to You, Your application, Amendments and any applicable Riders constitute the entire Policy. No change in this Policy will be valid until approved by one of Our executive officers, and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Examination of Covered Persons

In the event of a question or dispute regarding Your right to Benefits, We may require that a Network Physician of Our choice

examine You at Our expense.

Incentives to Providers

We pay certain providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect Your access to health care.

Examples of financial incentives for providers are bonuses for performance based on factors that may include quality, Member satisfaction, and/or cost effectiveness.

We use various payment methods to pay specific providers. From time to time, the payment method may change. If You have questions about whether Your provider has a contract with Us and if that contract includes any financial incentives, We encourage You to discuss those questions with Your provider.

Incentives to You

Sometimes We may offer coupons or other incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is Yours alone, but We recommend that You discuss participating in such programs with Your Physician. These incentives are not Benefits and do not alter or affect Your Benefits. Contact Us if You have any questions.

Incorporation by Reference

Unless otherwise stated herein, the Schedule of Coverage and Benefits, the schedule of rates and Premiums, any riders, the application, and any amendments to any of the foregoing, form a part of this Policy as if fully incorporated herein.

Information and Records

At times, We may need additional information from You. You agree to furnish Us with all information and proofs that We may reasonably require regarding any matters pertaining to the Policy. If You do not provide this information when requested, We may delay or deny payment of Your Benefits.

By accepting Benefits under the Policy, You authorize and direct any person or institution that has provided services to You to furnish Us with all information or copies of records relating to the services provided to You. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents, whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning Health Care Services that are necessary to implement and administer the terms of the Policy for appropriate medical review, quality assessment, or as We are required to do by law or regulation. During and after the term of the Policy, We and Our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of Your medical records or billing statements, We recommend that You contact Your health care provider. Providers may charge You reasonable fees to cover their costs for providing records or completing requested forms.

If You request medical forms or records from Us, We also may charge You reasonable fees to cover costs for completing the forms or providing the records.

In some cases, We will designate other persons or entities to request records or information from or related to You, and to release those records as necessary. Our designees have the same rights to this information as We have.

Interpretation of Eligibility and Benefits

We have sole discretion to do all of the following:

- Determine eligibility;

- Interpret Benefits under the Policy;
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this Policy and any Riders and Amendments;
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case shall not in any way be deemed to require Us to do so in other similar cases.

Legal Actions

You may not bring any action of law or in equity concerning a claims payment until sixty (60) days after written proof of claim for Benefit payment has been furnished to Us, in accordance with the requirements of the Policy. Any such action must be filed within three (3) years of the date a claim is required to be sent to Us.

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Covered Persons who are eligible for or enrolled in Medicare may NOT be covered under the Policy.

Misstatement of Age

If the age of the insured has been misstated, all amounts payable under this Policy shall be equal to the amount that the Premium paid would have purchased at the actual age when the policy was issued.

Notice

When We provide written notice regarding administration of the Policy to Your authorized representative, that notice is deemed notice to You and Your Enrolled Dependents.

Any notice required under this Policy will be sufficient if it is in writing, and mailed or delivered:

a) To You, when addressed to You at the address currently appearing on Our records; or
b) To Mercy Health Plans, when addressed to 14528 S Outer 40, Suite 300, Chesterfield, Missouri 63017-5743.

Policies, Identification Cards and Applications

We will furnish You with identification cards, copies of this Policy, and applications.

Reimbursement to Us

a) As a Covered Person, You agree to refund Us any benefit payment We made to You, or on Your behalf, for a claim paid or payable under Workers' Compensation or employers' liability law. Even if You fail to claim through a Workers' Compensation or employers' liability law, and You could have received payment through such a law if You had filed, reimbursement must still be made to Us. We have the right to credit payments of such claims against future claims in all cases.

b) We have the right to correct benefit payments paid in error. Hospitals, Physicians, other Providers and/or You have the responsibility to return any overpayment, including claims made involving fraud to Us. We have the responsibility to make additional payment if an underpayment is made.

Right of Reimbursement

In consideration of the coverage provided by this Certificate of Coverage, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us,
  - Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - Responding to requests for information about any accident or injuries,
  - Making court appearances, and
  - Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

Statements by Enrolling Individual or Subscriber

Except for fraudulent statements, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits, unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary.

Time Limit on Certain Defenses

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for charges incurred after the expiration of such three (3) year period.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by Workers' Compensation insurance.

Section 11: Covered Benefits

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
1. Ambulance Services- Emergency only	Medically Necessary ambulance service (either by a licensed ambulance service - ground or air ambulance) to the most appropriate Hospital where Emergency Care can be provided in the case of a Medical Condition and Medically Necessary transportation, however, use of air ambulance must be approved in advance or as soon as reasonably possible by the Plan. Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in emergency situations. See Section 12, R., for related exclusions.
2. Dental-Anesthesia and Facility Charges	Administration of general anesthesia and Hospital charges for dental care if: • The Covered Person is a child under the age of seven (7) who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or • The Covered Person is diagnosed with a serious mental or physical condition; or • The Covered Person has a significant behavioral problem as determined by the Plan. Limitations and Exclusions are described in Section 12, D. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits for dental anesthesia and related facility charges will be reduced by 50% of Eligible Expenses.
3. Diabetes Services	Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes. Coverage is provided for insulin infusion devices, insulin pumps, and associated supplies. Services for **diabetes self-management training**: Covered Health Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a licensed physician and a licensed health care professional must certify that the Covered Person successfully completed the training program. Coverage is limited to one(1) program during the entire time a Covered Person is Covered under this Certificate. A provider licensed, registered, and/or certified in the state to provide appropriate Health Care Services must provide diabetes self-management training program. Training is to be provided upon the initial diagnosis of diabetes, when there is a significant change in the Member's symptoms or when the Food and Drug Administration for the treatment of diabetes approve new techniques and treatments. **Prior Authorization Required** You must obtain Prior Authorization before receiving services for the following: ▪ Insulin pumps Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
4. Emergency Room Services	Emergency Room Services that are required to stabilize or initiate treatment in an Emergency. Emergency Room Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Room Services in Section 5 (How You

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Get Care). Physician charges may be applicable, if billed separately. See *Professional Fees for Surgical and Medical Services* below. Please remember that if You are admitted to a Hospital as a result of an Emergency, You must notify Us within two (2) working days or the same day of admission, or as soon as reasonably possible to receive authorization for continued services related to post-stabilization, as needed. If You don't notify Us, Benefits for the Hospital Inpatient Stay will be reduced to by 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services. Please refer to Hospital – Inpatient Stay below. If an Emergency Room admission results in a conversion to an Inpatient Stay or Observation Care, the Emergency room Copayment/Coinsurance charge will be waived when the hospital inpatient or observation admission for the same condition occurs within twenty-four (24) hours. The alternate higher level Copayment/Coinsurance will apply.
5. Hearing Screenings for Newborns	Newborn hearing screenings, necessary re-screening, audiological assessment and follow-up, and initial amplification.
6. Immunization – Routine Only	Routine immunizations as defined by the Plan. Coverage limitations may apply. Immunizations required for international travel are excluded. A list of routine immunizations can be obtained at **www.mercyhealthplans.com** or by calling Our Customer Contact Center at the number listed on Your ID card. There is no Copayment, Coinsurance or Deductible for routine immunizations. Applicable Copayments for office visit will apply. All other preventive health care services will be subject to Copayment, Coinsurance, Deductible, or dollar limit provisions.
7. Inpatient Hospital Services	Inpatient Hospital Services are available for: • Services and supplies received during the Inpatient stay. • Room and board in a Semi-private Room (a room with two or more beds), or • A private room only when medically necessary and approved in advance by the Plan. **Prior Authorization Required** Please remember that You must notify Us as follows: • For elective admissions; and • For Emergency admissions: within two (2) working days or the same day of admission, or as soon as is reasonably possible. Unless We pre-approve inpatient Hospital services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
8. In-Vitro Fertilization Services	Covered Health Services for In-Vitro Fertilization (IVF) include the following charges: • IVF associated lab; • Medication; • Imaging and procedures including female and male pre-testing; • The IVF process, and;

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	• Cryopreservation. Benefits are provided for in-vitro fertilization if the following conditions are met: • The patient's oocytes are fertilized with the sperm of the patient's Spouse, and • The patient and the patient's Spouse have a history of unexplained infertility of at least two (2) years' duration; or • The infertility is associated with one or more of the following medical conditions: • Endometriosis; • Exposure in utero to Diethylstilbestrol, commonly known as DES; • Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or • Abnormal male factors contributing to the infertility, and • The in-vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization. Any combination of Network and Non-Network Benefits is limited to a lifetime maximum benefit of $15,000 during the entire period of time You are covered under the Policy. **<u>Prior Authorization Required</u>** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
9. Maternity Services	Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any related complications. Sonograms in uncomplicated pregnancies are limited to two per pregnancy. We will pay Benefits for an Inpatient Stay of: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean Section delivery. • 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Early discharge requires that both of the following requirements are met: • The discharge complies with the guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. • The mother and child are provided post-discharge care as determined by the attending physician. Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician; and includes parent education, training in breast or bottle-feeding, and appropriate testing of the mother and child. Copayments and Deductible requirements apply to normal newborn admissions and both the mother and newborn will incur separate inpatient Copayments/Deductibles as follows: • If the mother and newborn are discharged from the same hospital on the same day, applicable Copayments/Coinsurances and Deductible will apply separately for the mother and the newborn; however, the Deductible will be waived for the newborn;

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	• If the mother and newborn are *not* discharged from the same hospital on the same day, both the mother and newborn will each incur applicable Copayments/Coinsurances and Deductibles for their inpatient hospital stay. The newborn's inpatient hospital Copayment/Coinsurance and Deductible will cover the dates of service *after* the mother's discharge, or dates of service at a different hospital. • If the newborn remains hospitalized after the mother's discharge date, an inpatient authorization is required for the dates of service after the mother's discharge date, and vice versa. See "Prior Authorization Required" below. **Note: The number of prenatal visits or change in Physician may effect Your Copayment/Coinsurance.** **Prior Authorization Required** Please remember that You must notify Us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. Unless We pre-approve any extended inpatient Hospital services beyond labor and delivery for either You or Your newborn, Your Network and Non-Network Benefits for the extended stay will be reduced by 50% of Eligible Benefits.
10. Newborn Child Coverage	Coverage for newborn children begins from the moment of birth. Benefits include coverage for illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, all other disorders of metabolism, and routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period. **Prior Authorization Required** We must be notified within ninety (90) days of birth, or Your next Premium due date, whichever is greater. If You don't notify Us, You will be responsible for paying 100% charges incurred after the lesser of five (5) days, or the mother's discharge date.
11. Observation Care	Observation Care are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services do not exceed one (1) day. Members may be admitted as Observation status to beds in the Emergency room, an observation unit, the intensive care unit, or a regular floor. If an Observation admission results in a conversion to an Inpatient Admission for the same condition within twenty (24) hours, the Observation Copayment will be waived. The alternate Copayment/Coinsurance will apply. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
12. Osteoporosis Services/Bone Mineral Density (BMD) Testing	Diagnosis, treatment, and appropriate management of osteoporosis for Covered Persons with a condition or medical history for which bone mass measurement is medically indicated. Coverage limitations may apply. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Prior Authorization Required Unless We pre-approve services requiring Prior Authorization, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
13. Outpatient Diagnostic Services	Covered Health Services received on an outpatient basis at a Hospital or Alernate Facility for laboratory and medical diagnostic services. • Laboratory servies; • X-ray/imaging services; • Other diagnostic tests and therapeutic treatments (including cancer Chemotherapy or intravenous infusion therapy). The following services are subject to the outpatient diagnostic charges regardless of the place of service: • MRA • MRI • CT Scan • PET Scan • Nuclear Cardiology Imaging studies Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on your ID card. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
14. Outpatient Surgery/Hospital Procedures	Covered surgical services and other medical care received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this Section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below, and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment. **Surgical Implants**, whether inserted in the inpatient, outpatient, or office setting, including pacemakers, stents, and other implantable devices or treatments. Copayment is consistent with type of service required. Implants for cosmetic or psychological reasons are excluded, see Section 12, L. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on your ID card. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
15. Physician's Office Services	Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury; • Preventive medical care; • Well-baby and well-child care including children's preventive health care services for children from birth through eighteen (18) years of age; • Routine physical examinations.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
16. PKU/Medical Foods and Low Protein Modified Food Products for Metabolic Disorders	Benefits are provided for Medical Foods and Low Protein Modified Food Products for Metabolic Disorders if the following are met: • The Medical Food or Low Protein Modified Food Products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; • The products are administered under the direction of a licensed physician; and • The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the $2,400 per year per person. See Section 12, J. for limitations and exclusions related to this benefit.
17. Preventive Health & Wellness Care	Preventive Health Screenings are for non-symptomatic persons in accordance with the American Cancer Society guidelines and Mercy Health Plans' preventive health guidelines. Preventive Health Screenings include one (1) routine test of each of the following every Calendar Year, unless otherwise indicated: • Cholesterol Tests • Colon Screening: – Colonoscopy – one (1) routine screening every ten (10) years – Double-contrast Barium Enema – one (1) routine screening every five (5) years – Flexible Sigmoidoscopy – one (1) routine screening every five (5) years – Fecal Occult Blood Test • Mammography • Pap Test • Pelvic Exam • Prostate Exam • PSA test [Preventive Health Screenings are covered in-Network with no Deductible. Deductible and Coinsurances will apply to services received from a Non-Network Provider.]
18. Professional Fees for Surgical and Medical Services	Professional fees for surgical procedures and other medical care provided in an outpatient facility. You may incur a separate copayment/coinsurance in addition to the outpatient facility charge. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.
19. Reconstructive Procedures	Services for reconstructive procedures, when a physical impairment exists, and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. See Section 12, L. for related limitations and exclusions. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast disease, and reconstruction of the Non-affected breast to achieve symmetry.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Reconstructive surgery for breast reconstruction and the receipt of a related prosthetic devices may follow a mastectomy at any time. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at the telephone number on Your ID card for more information about Benefits for mastectomy-related services. **Prior Authorization Required** You must notify Us before receiving services. When You notify Us, We can verify that the service is a reconstructive procedure, rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. Unless We pre-approve a Covered reconstructive Service, Network and Non-Network Benefits for reconstructive procedures will be reduced by 100% of Eligible Expenses.
20. Rehabilitation Services	***Outpatient Rehabilitation Therapy:*** Short-term outpatient rehabilitation services for: • Physical Therapy; • Occupational Therapy; • Speech Therapy; • Pulmonary Rehabilitation Therapy; • Cardiac Rehabilitation Therapy. Also includes covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for treatment for loss or impairment of speech or hearing. "Short-term" means rehabilitation services that are expected to result in significant physical improvement in Your condition within two (2) months of the start of treatment. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Home rehabilitation services are limited to the Homebound patient and considered separately under the home health Benefit. Please note that We will pay Benefits for Speech Therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Rehabilitation therapy services that are considered maintenance, developmental or educational in nature are not covered Benefits. Exclusions are described in Section 12, P. Any combination of Network and Non-Network Benefits is limited as according to Your Schedule of Coverage and Benefits. ***Inpatient Rehabilitation Services:*** Medically Necessary services for an Inpatient Stay in an Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-Private Room Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or non-elective inpatient rehabilitation admission. Unless We pre-approve inpatient rehabilitation services, Network and Non-Network Benefits will be reduced by

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	50% of Eligible Expenses. For emergency admission, You must notify Us within two (2) working days or as soon as reasonably possible.
21. Skilled Nursing Facility (SNF)	Medically Necessary services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay; • Room and board in a Semi-private Room. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or Non-elective admission. Unless we pre-approve SNF services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For emergency admissions, You must notify Us with two (2) working days or as soon as reasonably possible.
22. Urgent Care Center Services	Covered Health Services received at an Urgent Care Center. If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this Section.

Section 12: Exclusions – Things We Don't Cover

This Section contains information about Medical services that are not covered. We call these Exclusions. It's important for You to know what services and supplies are not covered under the Policy.

We do not pay Benefits for exclusions or any related complications.

We will not pay Benefits for any of the services, treatments, items or supplies described in this Section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for Your condition.

The services, treatments, items or supplies listed in this Section are not Covered Health Services, except as may be specifically provided for in Section 11 (Covered Benefits) or through a Rider to the Policy.

Category	Description
A. Allergy	We do not cover any allergy related injections and serum, treatment, or testing.
B. Alternative Treatments	We do not cover alternative treatments, including but not limited to: 1. Acupressure and Acupuncture. 2. Aromatherapy. 3. Hypnotism. 4. Massage Therapy. 5. Rolfing. 6. Herbal remedies. 7. Ayurvedic therapies. 8. Reflexology. 9. Biofeedback and neurofeedback therapy. 10. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
C. Comfort or Convenience	1. Television. 2. Telephone. 3. Beauty/Barber service. 4. Guest service. 5. Automated travel devices (motor scooters). 6. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include: - Air conditioners - Air purifiers and filters - Batteries and battery chargers - Dehumidifiers and Humidifiers - Electrostatic machines - Lights/lighting - Portable room heaters, grab bars, etc. - Vaporizers - Tanning booths - Bath chairs - Breast pumps, unless newborn in NICU - Exercise equipment - Raised or regular toilet seats - Whirlpools, saunas, and hot tubs 7. Devices and computers to assist in communication and speech. Augmentative communication devices, including, but not limited to, computer assisted speech devices, speech teaching machines, telephones, TDD equipment, Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, Non-digital voice systems, such as the Electro-Larynx, after post-radical neck or other invasive surgery that interferes with laryngeal function. 8. Personal hygiene items and hygienic items, including, but not limited to, shower chairs, commodes (unless the individual is confined to room or bed), incontinence pads, bed baths, etc. 9. Devices that are primarily non-medical in nature or used primarily for comfort,

Category	Description
	including, but not limited to: - Bed boards - Elevators - Foam pads - Heating pads - Beds other than standard single hospital beds - Overbed tables - Carafes - Emesis basins - Maternity belts - Bathtub seats - Standing tables 10. Chair lifts, bathtub lifts, bed lifter, and other similar devices. 11. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.
D. Dental	1. Dental care, including Accidental Dental, except as described in Section 12 (Covered Benefits) under the heading, "Dental – Anesthesia and Facility Charges". 2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following: – Extraction, restoration and replacement of teeth; – Medical or surgical treatments of dental conditions; – Services to improve dental clinical outcomes; – Services for overbite or underbite; – Services related to surgery for cutting through the lower or upper jaw bone; – Maxillary and mandibulary osteotomies 3. Dental implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded. 4. Dental braces and occlusal splints, even if associated with Accidental Dental Services. 5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: – Transplant preparation; – Initiation of immunosuppressives; – The direct treatment of acute traumatic Injury; – The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment); – Cleft palate; – Covered Persons with conditions outlined in Section 11 (Covered Benefits) under Dental – Anesthesia and Facility Charges; 6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly. 7. Orthodontic services. 8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. 9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer. 10. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint syndrome, except as a treatment of obstructive sleep apnea.
E. Drugs	1. Prescription drug products for outpatient use (including self-injectables) that are filled by a prescription order or refill. 2. Non-injectable medications given in a Physician's office except as required in an Emergency. 3. Over the counter drugs and treatments. 4. Charges for supplies for use beyond the first twenty-four (24) hours following

Category	Description
	discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any prescription drugs intended primarily for home use. 5. Injectables/Infusions provided in a Physician's office, infusion center or through home health.
F. Experimental, Investigational or Unproven Services	1. Experimental, Investigational or Unproven Services are excluded including routine patient care costs for phase II, III or IV of clinical trials undertaken for the purpose of the prevention, early detection and treatment of cancer. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
G. Foot Care	1. Routine foot care (including the cutting or removal of corns and calluses). 2. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection. 3. Hygienic and preventive maintenance foot care. Examples include the following: – Cleaning and soaking the feet; – Applying skin creams in order to maintain skin tone; and – Other services that are performed when there is not a localized illness, Injury or symptom involving the foot. 4. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet, unless otherwise noted in this document. 5. Treatment of subluxation of the foot. 6. Shoe orthotics, orthopedic shoes and other supportive appliances for feet**.**
H. Medical Supplies and Appliances	1. Devices used specifically as safety items or to affect performance in sports-related activities. 2. Prescribed or Non-prescribed medical supplies and disposable supplies. Examples include: – Elastic stockings – Ace bandages – Gauze and dressings – Disposable sheets and bags – Fabric supports – Surgical face masks – Incontinent pads, including diapers – Irrigating kits – Pressure leotards – Surgical leggings and support hose Exceptions include diabetic supplies. 3. All orthotic and prosthetic devices/equipment except for breast prosthetics following a mastectomy. 4. Tubings and masks. 5. Devices and equipment that are not normally appropriate outside of a hospital (or other provider) setting, including, but not limited to: – Home monitoring devices and supplies, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders) – Home prenatal monitoring and associated nursing support 6. Lift Seats. 7. DME is not covered except for Diabetes Services related equipment as described in Section 11 (Covered Benefits).
I. Mental Health/Substance Abuse	1. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders. 2. Psychosurgery.

Category	Description
	3. Vagus nerve stimulation (VNS) for depression. 4. Residential treatment services.
J. Nutrition	1. Megavitamin and nutrition based therapy (for any purpose). 2. Vitamins (other than those prenatal vitamins prescribed for a Member who is then pregnant). 3. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except for treatment of Diabetes only. 4. Medical foods and other nutritional and electrolyte supplements taken orally, parenterally or enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any inherited disease of amino or organic acids. 5. Nutritional Supplements when tube feeding is the sole source of nutrition is also excluded.
K. Personal	1. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: a. Required solely for purposes of career, education, sports or camp, travel, recreation, employment, insurance, marriage or adoption. b. Related to judicial or administrative proceedings or orders. c. Conducted for purposes of medical research. d. Required to obtain or maintain a license of any type. 2. Custodial Care. See Section 13 (Definitions of Terms). *3*. Domiciliary care or any nursing care on full-time basis in Your home. 4. Private Duty Nursing. See Section 13 (Definitions of Terms). 5. Respite care. 6. Rest cures. 7. Medical and surgical treatment of excessive sweating (hyperhidrosis). 8. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. 9. Oral appliances for snoring. 10. Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony. 11. Work place evaluations and work hardening treatment. 12. Home Health Care Services. 13. Hospice/Pallative Care. 14. Tobacco Cessation education program and products. 15. Dialysis.
L. Physical Appearance	1. Cosmetic Procedures. See the definition in Section 13 (Definitions of Terms). Examples include: – Pharmacological regimens, nutritional procedures or treatments. – Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). – Skin abrasion procedures performed as a treatment for acne. – Liposuction. – Hair transplant for baldness. – Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears. – All other cosmetic services **except** if medically necessary to: i. Repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan; ii. Restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Member under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of normal human variation; or iii. Reconstructive breast surgery performed post-mastectomy. 2. Replacement of an existing breast implant, if the earlier breast implant was performed

Category	Description
	as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 11 (Covered Benefits). 3. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. 4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. 5. Wigs, regardless of the reason for the hair loss except as otherwise provided by law. 6. Treatment of benign gynecomastia (abnormal breast enlargement in males). 7. Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office visits associated with any weight loss program. 8. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded. 9. Sex transformation operations. 10. Breast Reduction Surgery (Reduction Mammoplasty).
M. Providers	1. Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. 2. Services performed by a provider with Your same legal residence. 3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who *is* an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider: a. Has not been actively involved in Your medical care prior to ordering the service, or b. Is not actively involved in Your medical care after the service is received. This exclusion does not apply to mammography testing. 4. Charges Incurred for broken appointments with a Participating Physician.
N. Reproduction	1. Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy. 2. Surrogate parenting. 3. Voluntary sterilization or the reversal of voluntary sterilization. 4. Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother. 5. Contraceptive supplies and services 6. Fetal reduction surgery. 7. Health services associated with the use of Non-surgical or drug induced Pregnancy termination. 8. Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function, unless otherwise covered in this Policy.

Category	Description
O. Services Provided under Another Plan	1. Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. 2. Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by Workers' Compensation or similar law. If coverage under Workers' Compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under Workers' Compensation or similar legislation, if that coverage had been elected. 3. Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage, and facilities are reasonably available to You. 4. Health services while on active military duty. Upon notifying Mercy Health Plans of entry into military service, any pro-rata unearned premiums shall be refunded. 5. Injury or Illness incurred while incarcerated in any local, municipal, state or Federal facility.
P. Therapies/Psychological Testing	1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin (unless otherwise covered under this Policy, or by law). Speech Therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Cognitive therapy. 3. Psychological testing for any reason. 4. Neuropsychological Testing for any reason. 5. All Educational Services, including treatment of learning disorders and acquired cognitive deficits. 6. Water exercise and other exercises not under the supervision of a physical therapist. 7. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 8. Therapy for conditions such as developmental delay, ADHD, and autism.
Q. Transplants	1. Health services for organ and tissue transplants. 2. Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. 3. Health services for transplants involving mechanical or animal organs.
R. Travel	1. Health services provided in a foreign country, unless required as Emergency Care Services. 2. Travel or transportation expenses, even though prescribed by a Physician, except for medically necessary ambulance services. 3. Air ambulance services outside the continental United States for any reason.
S. Vision and Hearing	1. Purchase cost of eye glasses, contact lenses (except for eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a $300.00 dollar benefit per lifetime), or hearing aids. 2. Fitting charge for hearing aids, eye glasses or contact lenses. 3. Eye exercise therapy (orthoptics or pleoptic training). 4. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery. 5. Routine eye examination by an ophthalmologist or optometrist for the correction of refractive errors.

Category	Description
T. General/ Administrative	1. Health services and supplies that are not included in Section 11 (Covered Benefits), or that do not meet the definition of a Covered Health Service - see the definition in Section 13 (Definitions of Terms). 2. Health services received as a result of any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country. 3. Health services received after the date Your coverage under the Policy ends, including health services for medical conditions arising before the date Your coverage under the Policy ends. 4. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. 5. Charges in excess of the Usual and Customary Rate (UCR) or in excess of any specified limitation. 6. Complications of Health Care Services that are not Covered Health Services. 7. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan. 8. Autopsies (post-mortem exams).

Section 13: Definitions of Terms

Adverse Determination A decision by Mercy Health Plans that an admission, availability of care or continued stay has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness leading to a decision that coverage for the requested service is denied, reduced or terminated.

Alternate Facility A health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

Amendment Any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible/Deductible If applicable, the amount You must pay for Covered Health Services in a [Calendar] [Plan] Year before We will begin paying for Benefits in that [Calendar] [Plan] Year. Deductible amounts are separate from and not reduced by Copayments. Deductible and Copayments are in addition to any Coinsurance You pay.

Benefits Your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this Policy of Coverage and any attached Riders and Amendments.

Calendar Year January 1 through December 31 of the same year.

Cardiac Rehabilitation A comprehensive program to rehabilitate the heart.

Case Management A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health Conditions. Case Management may include:

1. Assessment of Your individual benefit needs;
2. Formulation and modification of a comprehensive benefit plan of action;
3. Coordination of Benefits;
4. Evaluation of the effectiveness of the plan of action; and
5. Negotiation of extra-contractual services, if necessary.

Certificate of Coverage This document including all Riders, Amendments and Schedule of Coverage.

Chemotherapy Treatment of disease by FDA-approved antineoplastic agents.

Coinsurance Coinsurance is the percentage of Our allowance that You must pay for Your care. You may also be responsible for other costs for Your care such as a Deductible. See Section 6 (Your Cost for Covered Services).

Complications of Pregnancy Any complications associated with Pregnancy, i.e., conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest period during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Congenital Anomaly

A physical developmental defect that is present at birth, and is identified within the first twelve (12) months of birth.

Copayment

A Copayment is a fixed amount of money You pay when You receive Covered Services. See SSection 6 (Your Cost for Covered Services).

Cosmetic Procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Us.

Covered Health Service(s)/Covered Services

A Covered Health Service is a Health Care Service or supply which is not excluded under Section 12 (Exclusions) and meets the following conditions:

1) Prescribed by a Physician for the therapeutic treatment of Injury, Illness or Complications of Pregnancy;
2) Deemed Medically Necessary and appropriate in type, level, setting, and length of service; and if required by the Plan, is authorized on a prospective and timely basis by the Plan's Medical Director.
3) Rendered in accordance with generally accepted medical practice and professionally recognized standards;
4) Provided on or after the Effective Date and before Your coverage terminates in accordance with Section 4 (When Coverage Ends) and at a time when You met all applicable requirements for eligibility set forth in Section 3 (When Coverage Begins).

Covered Person

Either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "You" and "Your" throughout this Policy are references to a Covered Person.

Custodial Care

Services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent

The Subscriber's legal Spouse or an unmarried Dependent child of the Subscriber. The term child includes any of the following:

- A natural child;
- A stepchild;
- A legally adopted child;
- A child placed for adoption;
- A child for whom permanent legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse.

To be eligible for coverage under the Policy, a Dependent's domicile and his/her primary residence must be in Arkansas. The definition of Dependent is subject to these conditions and limitations:

- A Dependent includes any unmarried dependent child under 19 years of age;
- A Dependent includes an unmarried dependent child who is 19 years of age or older to [23 – 25] years of age, only if You furnish evidence upon Our request, satisfactory to Us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.

A Dependent also includes a child for whom health care coverage is required through a

'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Individual is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility

A Hospital that We name as a Designated Facility. A Designated Facility has entered into an agreement with Us, or with an organization contracting on Our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within Our geographic area.

Durable Medical Equipment (DME)

Medical equipment that is all of the following:

- Can withstand repeated use;
- Is not disposable;
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Is generally not useful to individuals in the absence of a Sickness, Injury or their symptoms;
- Is appropriate for use in the home.

Eligible Expenses

The amount We will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

Eligible Expenses are determined solely in accordance with Our reimbursement policy guidelines. We develop Our reimbursement policy guidelines, in Our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications.
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that We accept.

Eligible Person

An Eligible Person is a Subscriber or Dependent that was covered under the [group] Policy this conversion Policy replaces on the date of termination of such group Policy. An Eligible Person's domicile and his/her primary residence must be located within Arkansas. In addition, an Eligible person is not/cannot be covered by Medicare, or by another health insurance policy, whether individual or group, or by similar benefits provided by any state or federal law.

Emergency

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but will not be limited to, any of the following:

- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain;
- With respect to a pregnant woman who is having contractions, either of the following:
  - Inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery;
  - The transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Care/Emergency Room Services

Health Care Services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent A Dependent who is properly enrolled under the Policy.

Enrolling Individual The individual to whom the Policy is issued.

Experimental or Investigational Services Medical, surgical, diagnostic, psychiatric, substance abuse or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

External Independent Reviewer A clinical peer with no direct financial interest in connection with the Grievance/appeal in question and who has not been informed of the specific identity of the Enrollee.

External Review A process, independent of all affected parties, to determine if a Health Care Service is medically necessary or Experimental/Investigational.

Full-Time Student An unmarried dependent child who is between the ages of 19 – 23 that meets all the following conditions:

- The child must not be regularly employed on a full-time basis;
- The child must be primarily dependent upon the Subscriber for support and maintenance;
- The child must be attending, fulltime, a recognized course of study or training at one of the following:
  - An accredited high school;
  - An accredited college or university;
  - A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student on the date You graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If You do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Grievance A written Complaint submitted by or on behalf of a Member regarding the a) availability, delivery or quality of Health Care Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; b) claims payment, handling or reimbursement for Health Care Services; or c) matters pertaining to the contractual relationship between a Member and the Company.

Health Care Service(s) Those health services provided for cosmetic or other non-medical purposes, or for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

Homebound Homebound means an individual who is confined to the home as a result of their physical or mental condition and that leaving home is a major effort and normally requires assistance. Leaving home is done to receive medical care or for short, infrequent non-medical reasons such as a trip to the grocery store, beauty parlor or barbershop, or to attend religious services.

Hospital A legally constituted institution, having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facilities are operated as a separate institution by a hospital.

Implant(s) That which is implanted such as a piece of tissue, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purpose. Examples of surgical Implants include stents, artificial joints, shunts, grafts pins, plates, screws, anchors and radioactive seeds.

Infertility The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful Pregnancy. (Sexual intercourse means the sexual union between a male and female). Infertility does not include individuals unable to conceive post sterilization.

Initial Enrollment Period The initial period of time, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Low Protein Modified Food Products Food products specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Maximum Policy Benefit The maximum amount that We will pay for Benefits during the entire period of time that You are enrolled under the Policy issued to the Enrolling Individual. The Maximum Policy Benefit includes any amount that We have paid for Benefits under a former Policy issued to the Enrolling Individual that is replaced by the current Policy, as well as any amount that We may pay under a later Policy that replaces the Enrolling Individual's current Policy. When the Maximum Policy Benefit applies, it is described in Section 6 (Your Cost for Covered Services).

Medical Foods Products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

Medically Necessary Health Care Services that are ordered by a Health Provider, without which there would be significant risk of a serious deterioration and/or a significant impairment that, if not treated, could seriously affect one's ability to function within his or her normal environment. Although some Health Care Services are medically acceptable, they may not be medically necessary. Health Care Services need to be (1) medically appropriate and necessary to meet the basic health needs of the Member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; (4)

consistent with the diagnosis of the conditions; and (5) of demonstrated medical value. Medically Necessary does not include care that is provided primarily for the convenience of the Member or a Health Provider, or care that is rendered more frequently than that accepted as medically appropriate by the medical profession.

Medicare Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Member A Member means any Subscriber or Dependent.

Mental Illness Those Conditions classified as mental disorders in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, except mental retardation

Network Benefits Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network provider in the provider's office or at a Network or Non-Network facility.

Network/Network Provider When used to describe a provider of Health Care Services, this means a provider that has a participation agreement in effect with Us or with Our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of Our products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement, and a Non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

Neuropsychological Testing Neuropsychological Testing is a quantitative, comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders.

Non-Network Benefits Benefits for Covered Health Services that are provided by a Non-Network Physician or other Non-Network provider.

Observation Care Care in the Hospital to monitor evaluate or stabilize a patient in order to determine the need for further treatment or an inpatient admission. Such Care is not considered Inpatient Care, even though the patient may be confined to a Hospital bed.

Occupational Therapy Treatment of a physically or mentally disabled person through constructive activities designed to restore the ability to accomplish satisfactorily the ordinary activities of daily living. Activities of daily living include feeding, dressing, bathing and other types of self-care.

Out-of-Pocket Maximum If applicable, the maximum amount of Coinsurance You pay every CalendarYear. If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that Calendar Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that Calendar Year. See Section 6 (Your Cost for Covered Services).

Physical Therapy Treatment by physical means including hydrotherapy, heat, physical agents, and biomechanical and neurophysiological principles and devices that relieve pain or restore maximum bodily function. Physical Therapy does not include Cardiac Rehabilitation, Pulmonary Rehabilitation or Manipulation/Adjustment.

Physician Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that We describe a provider as a Physician does not mean that Benefits for

services from that provider are available to You under the Policy.

Policy This document including all riders, Amendments and Schedule of Coverage.

Policy Charge The sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy Includes all of the following:

- Prenatal care;
- Postnatal care;
- Childbirth.

Premium The periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Prior Authorization Precertification review by the Plan, before services and treatment are rendered, to determine if the service meets the criteria as a Covered Health Service.

Preventive Health Screening(s) Routine tests performed on a healthy individual who has no signs or symptoms of disease, or history of the disease being screened. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient or a patient previously diagnosed with the disease being screened are classified as diagnostic tests. Diagnostic tests will incur Deductibles and/or Copayments/Coinsurances consistent with the services received.

Private Duty Nursing Private Duty Nursing is defined as one-on-one care provided on an individual basis either in an institution or in a patient's home. Private duty skilled nursing care can be considered custodial after Non-professional personnel repetitively performs the care, making continuous attention by a health professional no longer necessary, and is therefore not a covered benefit.

Pulmonary Rehabilitation A comprehensive program to manage patients with substantial chronic lung disease. Includes diagnostic testing, monitored dynamic exercise and education under the direct supervision of a qualified Physician.

Rider Any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-Private Room A room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Health Service, the difference in cost between a Semi-Private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.

Sickness Physical illness, disease or Pregnancy. The term Sickness as used in this Policy does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal Care, Custodial Care, ambulatory Care, part-time Care, or Care for Mental Illness and Substance Abuse, pulmonary tuberculosis or venereal disease.

Speech Therapy Treatment for loss or impairment of speech or hearing, including communicative disorders resulting from genetic defects, birth defects, injury, illness, disease, developmental disabilities or delays or other causes, whether of organic or nonorganic etiology and whether or not the person suffering from that loss or impairment had the capacity for speech, language or hearing before the loss or impairment occurred.

Subscriber An Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued.

The Plan The Plan refers to Mercy Health Plans.

Unproven Services Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a Individual of patients who receive standard therapy.
- The comparison Individual must be nearly identical to the study treatment Individual.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Urgent Care Center A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of Your health, within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Us/We/Our Us/We/Our refers to Mercy Health Plans.

Usual and Customary Rate (UCR) Charges for Covered Health Services which do not exceed the fees and prices generally approved for cases of comparable nature and severity at the time and place when such Covered Services are rendered or received. In determining the Usual and Customary Rate (UCR), the following guidelines shall be taken into consideration:

a) The rate allowed by Medicare for that particular service or supply;
b) The prevailing rate of fees charged for identical or similar services in the same geographical area by health professionals of similar training and experience;
c) Unusual circumstances or complications that require additional time, skill and experience in connection with the provided service or supply;
d) The actual charge by the Provider (if less than Our UCR charge);
e) The frequency of the determination of the usual and customary fee;
f) A general description of the methodology used to determine usual and customary fees;
g) The percentile that determines the maximum benefit the Plan will pay for any Accidental Injury dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then making the benefit by selecting a percentile of those fees.

Utilization Review A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of Health Care Services, procedures or settings. Utilization Review may include Ambulatory Review, Prospective Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning or Retrospective Review, but will not include elective requests for clarification of Coverage.

You/Your You/Your refers to the Subscriber and each Enrolled Dependent.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MHP, Inc. by and on behalf of its wholly-owned subsidiaries, including Mercy Health Plans of Missouri, Inc., Mercy Health Plans, and Premier Benefits, Inc. (Collectively referred to as "the Plan"), respects the privacy of its Members and former Members and protects the security and confidentiality of their nonpublic personal information. We have instituted internal policies to: insure the security and confidentiality of Your personal and financial healthcare information; protect against any anticipated threats of hazards to the security or integrity of such records; and protect against unauthorized access to or use of information which could result in substantial harm or inconvenience to You. We are required by law to provide You with this Notice of Our legal duties and privacy practices. This Notice explains Your rights, Our legal duties, and Our privacy practices. To fulfill Our responsibilities to You, the Plan may use and disclose Your protected health information for treatment, payment, and healthcare operations, or when We are otherwise required or permitted to do so by law. Below is further detail explaining these situations.

TREATMENT
We may use and disclose protected health information with Your healthcare providers (physicians, pharmacies, hospitals and others) to assist in the diagnosis and treatment of Your injury or illness. For example, We may disclose Your protected health information to suggest treatment alternatives.

PAYMENT
We may use and disclose protected health information to pay for Your covered health expenses. For example, We may use protected health information to process claims. We may also ask a healthcare provider for details about Your treatment so that We may pay the claim for Your care.

HEALTHCARE OPERATIONS
We may use and disclose protected health information for Our healthcare operations. For example, We may use or disclose protected health information to perform quality assessment activities or provide You with case management services.

BUSINESS ASSOCIATES
We may, at times, need to use the services of other companies in lieu of Our own staff, such as outsourcing data entry services, or, as part of Our routine business, We may require that outside entities, such as auditors perform operations that require access to Our healthcare information. In order for Us to share confidential information with these organizations, We must enter into agreements that require them to comply with the privacy regulations of the Plan.

YOU OR YOUR PERSONAL REPRESENTATIVE
We must disclose Your health information to You as described in the Patient Rights Section below. If You have a legally-assigned personal representative or are an un-emancipated minor, We will release the information to Your personal representative or parent(s) as required by law.

FAMILY/FRIENDS
We may disclose Your health information to a family member or friend to the extent necessary to help with Your healthcare or with payment for Your healthcare, if You agree that We may do so. If You wish to designate a person(s) to whom We may discuss Your healthcare, You may submit a request to the address listed below. If You are physically or mentally unable to participate in decisions regarding Your healthcare, We may need to communicate with a family member; however, only to the extent necessary to insure that You receive appropriate healthcare treatment.

PERMITTED OR REQUIRED BY LAW
We must disclose protected health information about You when required to do so by law. Information about You may be used or disclosed to regulatory agencies, such as Medicare and Medicaid; for administrative or judicial hearings; public health authorities; or law enforcement officials, such as to comply with a court order or subpoena.

MEMBER AUTHORIZATION
Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding protected health information that the Plan maintains about You. If You wish to exercise any of these rights, You may submit Your request in writing.

- Right to Access Your Protected Health Information. You have the right to inspect and/or obtain a copy of individual protected health information that We maintain about You. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance.

- Right to Amend Your Protected Health Information. You have the right to request an amendment of individual protected health information that We maintain about You. All requests must be in writing and must include the reason for the change.

- Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of disclosures of individual protected health information made by the Plan on or after the compliance date of April 14, 2003. All requests must be in writing and must state the period of time for which You want the accounting. We may charge for providing the accounting, but We will tell You the cost in advance.

- Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that the Plan restrict the use and disclosure of Your protected health information for treatment, payment, or healthcare operations. The Plan is not required to agree to the requested restriction; however, if the Plan does agree to the restriction, it must comply with Your request, unless the information is needed for an emergency.

- Right to Receive Confidential Communications. You have the right to request to receive communication of protected health information from the Plan through an alternative procedure (other than the standard means of communicating protected health information). All requests must be in writing and are subject to technical reasonability for the Plan.

- Right to a Paper Copy of This Notice. You have the right at any time to receive a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.

CHANGES
The Plan reserves the right to change the terms of this Notice at any time, effective for protected health information that We already have about You as well as any information that We receive in the future. We are required by law to comply with whatever Notice is currently in effect. We will communicate changes to Our Notice through subscriber newsletters, direct mail and/or Our Internet website (www.mercyhealthplans.com).

COMPLAINTS
If You believe Your privacy rights have been violated, You have the right to file a complaint with the Plan and/or with the Federal Government. Complaints to the Plan may be directed to the appropriate Customer Contact Center listed at the end of this Notice or by calling the Customer Contact Center number listed on the back of Your ID card. You may also file a complaint anonymously by calling the Plan's Fraud and Abuse Hotline at 1-877-349-5997. Complaints to the government may be sent to: Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.

CONTACT THE PLAN
If You want more information about this Notice, how to exercise Your rights, or how to file a complaint, please direct Your correspondence to the appropriate Customer Contact Center listed at the end of this Notice or call the Customer Contact Center phone number listed on the back of Your ID card. You can also contact Us through Our Internet website: www.mercyhealthplans.com

Mercy Health Plans
ATTN: Customer Contact Center
14528 S Outer 40, Suite 300,
Chesterfield, MO 63017-5743

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for Your policy, contract or any portion of it that is not guaranteed by the insurer, or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverage, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act, or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);

- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a non-affiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance Benefits, $300,000 in present value of annuity Benefits, or $300,000 in life insurance death Benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity Benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those Benefits could be provided out of the assets of the impaired or insolvent insurer.

Your Individual Conversion Policy

Issued by: Mercy Health Plans

This Individual Conversion Policy is guaranteed renewable

NOTICE:

The Benefits in this Policy do not necessarily equal or match those Benefits provided in Your previous group Policy

This Health Plan is underwritten by Mercy Health Plans. The Benefits and main points of coverage under the Plan are set forth in this Individual Conversion Policy and Schedule of Coverage and Benefits and any attached Riders. The Benefits are effective only while You are covered by this conversion Policy. The Benefits in this Policy do not necessarily equal or match those benefits provided in your previous group Policy.

This Policy describes the Benefits for health care services provided by Mercy Health Plans and the extent to which Benefit Payment may be limited. The Policy may be terminated by Mercy Health Plans or by You as described in this Policy.

You may return this Policy within ten (10) days of its receipt for full refund of any Premiums paid if, after examining it, You are not satisfied for any reason. Written notification is required to return this Policy. If services are utilized during this (10) day period, this policy is assumed to be accepted. Any coverage returned for a refund of premium will be null and void from its inception.

Mercy Health Plans
14528 S Outer 40, Suite 300
Chesterfield, Missouri 63017
314-214-8100
800-830-1918
www.mercyhealthplans.com

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Individual Health Conversion Policy

The Individual Health Conversion Policy is a legal document between **Mercy Health Plans** (**"The Plan", "We", "Us", "Our"**) and **the Enrolling Individual** (**"You", "Your"**) to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrollee's application and payment of the required Policy premium within thirty (30) days after termination from Your group health policy.

The Policy includes:

- The Enrollee's application;
- Any Amendments and Riders;
- The Schedule of Coverage and Benefits and any inserts to the Conversion Policy.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens We will send You the revised Policy, Rider or Amendment pages.

No one has the authority to make any changes to the Policy unless those changes are in writing and signed by an officer of Mercy Health Plans. No change shall be valid until approved and made part of the Policy. Only the Plan has the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without Your approval.

Information You Should Have

This Policy describes Benefits in effect as of Effective Date of Policy Issuance.

On its Effective Date, this Policy replaces and overrules any Policy that We may have previously issued to You, or Your employer. This Policy will in turn be overruled by any Policy We issue to You in the future.

Coverage under the Policy will begin at 12:01 a.m. on the Effective Date and end at 12:00 midnight on the Termination Date. The Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to termination of the Policy.

This Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

We are delivering the Policy in the State of Arkansas. The laws of the State of Arkansas govern this Policy.

The validity of the Policy will not be contested after the Policy has been in force for three (3) years from the date of issue. No statement relating to insurability, made by any person covered under the Policy, will be used to contest the validity of the Policy after it has been in force for a period of three (3) years. In addition, the statement must be contained in a written instrument signed by the person making the statement. The assertion, at any time, of defenses based upon the person's ineligibility for coverage under the Policy, or upon other provisions in the Policy, will not be precluded.

Section 1: Introduction to Your Policy

We encourage You to read Your Policy and any attached Riders and/or Amendments carefully.

Information about Defined Terms

Because this Policy is part of a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in Section 13 (Definitions of Terms). You can refer to Section 13 as You read this document to have a clearer understanding of Your Policy of Coverage.

When We use the words **"The Plan"**, **"We", "Us", and "Our"** in this document, We are referring to **Mercy Health Plans.** When We use the words **"You" and "Your",** We are referring to people who are **Covered Persons** as the term is defined in Section 13 (Definitions of Terms).

This Policy and the other Policy documents describe Your Benefits as well as Your rights and responsibilities under the Policy.

We especially encourage You to review the Benefit limitations of this Policy by reading Section 11 (Covered Benefits) and Section 12 (Exclusions). You should also carefully read Section 10 (General Provisions) to better understand how this Policy and Your Benefits work. You should call Us if You have questions about the coverage available to You.

Many of the Sections of the Policy are related to other Sections of the document. You may not have all of the information You need by reading just one Section. We also encourage You to keep Your Policy and any attachments in a safe place for Your future reference.

Please be aware that Your Physician does not have a copy of Your Policy of Coverage, and is not responsible for knowing or communicating Your Benefits.

Required Premiums, Premium Changes and Grace Period

The Plan requires payment of Premiums by the 15th of each month for this Policy. You must pay the required premium within a 31-day grace period to keep this Policy in force. All premiums must be paid via any one of the following methods:

- ACH Direct Debit Program
- Credit Card payment
- A check for the entire annual Premium

Your Conversion Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

Upon the payment of a claim under this Policy, any Premium then due and unpaid or covered by any note or written order may be deducted from the claim payment. We may change the amount of Your Premiums on any monthly due date upon giving You sixty (60) days prior written notice.

We may change the terms and conditions of this Policy to conform to the laws of the State of Arkansas, to conform to Federal law or to conform to underwriting policies established by Mercy Health Plans, after submission to and approval by the Arkansas Insurance Department. For changes in terms and conditions, We must give written notice thirty (30) days before the change. This notice may be in the form of a new Policy, or a Rider or Amendment to this Policy.

Don't Hesitate to Contact Us

Throughout the document You will find statements that encourage You to contact Us for further information. Whenever You have a question or concern regarding Your Benefits, please call Us using the telephone number for Our Customer Contact Center listed on Your ID card.

Section 2: Eligibility

How to Enroll

If Eligible, the Enrolling Individual must complete an enrollment application and submit the properly completed form to Us, along with any required Premium within thirty (30) days after termination of Your group health policy. We will not provide Benefits for health services that You receive before Your Effective Date of coverage.

If You Are Hospitalized When Your Coverage Begins

If You are a patient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the effective date of this Policy, We will pay Benefits for Covered Health Services related to that Inpatient Stay as long as You receive Covered Health Services in accordance with the terms of the Policy.

If You are hospitalized when Your coverage begins, You should notify Us within forty-eight (48) hours of Your effective date, or as soon as is reasonably possible. Network Benefits are available only if You receive Covered Health Services from Network Providers.

Who is Eligible for Coverage?

To be eligible for this coverage, Your primary domicile must be within Arkansas.

A converted policy need not be made available if termination occurred for any of the following reasons:

- You failed to make timely payment of any required contribution.
- The Group Policy terminated or a group's participation terminated, and the insurance is replaced by similar coverage under another Group Policy within thirty-one (31) days of the date of termination.
- An individual may convert to a conversion policy and remain covered by that policy until all preexisting conditions are covered or would be covered under another group policy or contract.

Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under your group Policy.

The converted policy shall cover the employee or Member and his/her Dependents who were covered by the Group Policy on the date of termination of insurance.

Who is Not Eligible to Enroll?

We are not required to issue a converted policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted policy covering any person if:

- Such person is or could be covered for similar benefits by another individual policy;
- Such person is or could be covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured, or similar benefits are provided for or available to such person, by reasons of state or Federal law; and
- The benefits under sources of the kind referred to above for such person, or benefits provided or available under sources of the kind referred to above for such person, together with the converted policy's benefits would result in over-insurance according to the insurer's standards for over-insurance.

Persons not eligible for coverage include –

a) Those whose coverage was previously terminated for the following causes:
    - Fraud or misrepresentation in the application;
    - Abuse of services or facilities;
    - Improper use of ID Card;
    - Misconduct detrimental to Plan operations and the delivery of services;
    - Failure to pay Premiums more than twice in the past 12 months, or to pay Premiums in a timely manner in accordance with the terms of the Policy.

Refer to Section 4 (When Coverage Ends) for a detailed description of these causes that lead to termination.

Section 3: When Coverage Begins

Initial Enrollment Period

The Initial Enrollment Period is the first time You enroll Yourself and/Your eligible Dependents, subject to acceptance by the Plan. Coverage begins on the Effective Date as determined by the Plan and when We approve Your completed application and receive any required Premium. Only a Subscriber or Dependent that was covered under the group Policy this conversion Policy replaces on the date of termination of such group Policy are Eligible to enroll in this Policy.

Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is Totally Disabled because of a mental or a physical disability will not end just because the child has reached a certain age. We will extend the coverage for the disabled child beyond the limiting age if both of the following are true:

- The disabled child is not able to be self-supporting because of a mental or physical disability; **and**
- The disabled child depends primarily on the Subscriber for support and maintenance due to the mental or physical disability.

Coverage will continue as long as the Enrolled Dependent is disabled and continues to satisfy both of these qualifying conditions, unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask You to furnish Us with proof of the disabled child's incapacity and dependency within a reasonable time after the date coverage would otherwise have ended because the child reached a certain age. Before We agree to this extension of coverage for the child, We may require that a Physician chosen by Us examine the child. We will pay for that examination.

We may continue to ask You for proof that the disabled child still meets these two conditions, but will not ask more than once per year. The proof We ask for might include medical examinations at Our expense.

If You do not provide proof acceptable to Us of the disabled child's incapacity and dependency, as described above, coverage for that child will end.

Section 4: When Coverage Ends

General Information about When Coverage Ends:

- We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.
- Your entitlement to Benefits automatically ends on the date that coverage ends, even if You are hospitalized or are otherwise receiving medical treatment on that date.
- When Your coverage ends, We will still pay claims for Covered Health Services that You received before Your coverage ended. However, once Your coverage ends, We do not provide Benefits for health services that You receive for medical conditions that occurred after Your coverage ended.
- An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Events Ending Your Coverage

Your coverage ends on the earliest of the dates specified in the following outline:

Event	Description
The Entire Individual Policy Ends	Your coverage ends on the date the Individual Policy ends. The Plan is responsible for notifying You that Your coverage has ended.
You Are No Longer Eligible for Coverage	Your coverage ends on the date You are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 2 (Eligibility) and Section 13 (Definitions of Terms) for more information. **When You turn age 65 or become eligible for Medicare, or have full coverage by a similar health insurance plan (group or individual) which provides benefits for all preexisting conditions, or are eligible for similar benefits provided by state or federal laws, You are no longer eligible for this conversion coverage.** If Your coverage ends due to Your death and We receive notification within one (1) year of Your death, Premiums paid for coverage beyond the date of Your death will be refunded to You or Your estate within thirty (30) days after We receive written proof of Your death.
We Receive Notice to End Coverage	Your coverage ends at the end of the month that We receive Your request in writing. We must receive Your termination notice **prior** to Your requested date of termination. Your Conversion Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period.
Fraud, Misrepresentation or False Information	Your coverage ends on the date We identify, in a notice, that Your coverage is terminated because of fraud or misrepresentation. We will provide written notice to the Subscriber that coverage has ended. During the first three (3) years the Policy is in effect, if You provided Us with false information or misrepresentation of material facts regarding Your application or coverage, We have the right to demand that You pay back all Benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under the Policy. After the first three (3) years, We can only demand that You pay back these Benefits if the written application contained a fraudulent misstatement.

Event	Description
Abuse of Services or Facilities	In the event of abuse by a Covered Person in the use of services or facilities, that person's coverage may be restricted or canceled by the Plan upon at least thirty-one (31) days' prior written notice to the Member.
Death of Subscriber	Coverage ends for the Subscriber and his/her Dependents as of the date of the Subscriber's death.
Improper Use of ID Card	Your coverage ends when You permit an unauthorized person to use Your ID card, or You used another person's card. When Your coverage is terminated because of improper use of Your ID card, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice.
Misconduct	In the event Your misconduct is detrimental to the safe Plan operations and the delivery of services, Your coverage may be cancelled immediately.
Moving Out of State	Coverage will end within sixty (60) days after We receive notice of Your move out of Arkansas.
Non-Payment of Premiums	This Policy will automatically end on the last day of the period for which Premiums have been paid. If Premiums are not paid within the grace period, thirty-one (31) days from the premium due date, there will be no reinstatement.

Section 5: How You Get Care

Identification cards

We will send You an identification (ID) card when You enroll. You should carry Your ID card with You at all times. You must show it whenever You receive services from a Network Provider. If You do not show Your ID card, Network Providers have no way of knowing that You are enrolled under Our Conversion Policy. As a result, they may bill You for the entire cost of the services You receive.

If You do not receive Your ID card within thirty (30) days after the Effective Date of Your enrollment, or if You need replacement cards, call Us at 866-647-5568. You must show Your ID card every time You request Health Care Services from a Network Provider.

Where You get covered care

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Individual Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 4 (When Coverage Ends) occurs.
- The person who received Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

You will only pay Copayments, Deductibles, and/or Coinsurances when receiving care from a Network Provider for a Covered Health Service. If You use Non-Network Providers, it will cost You more.

Network Providers

Network Providers are Physicians and other health care professionals that We contract with to provide Covered Services to Our Members. Network Providers are independent practitioners. They are not Our employees. It is Your responsibility to select Your provider. We credential Network Providers according to national standards. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

A directory of Network Providers is available on our website at www.mercyhealthplans.com We update the provider directory periodically. However, before obtaining services You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Our Customer Contact Center at 866-647-5568.

It is possible that You might not be able to obtain services from a particular Network Provider. The Network of providers is subject to change. You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of Our products. Refer to Your provider directory or contact Us for assistance.

Extended Provider Network

Mercy Health Plans has an extended provider network **outside** of Our contracted network called Private Healthcare Systems Preferred Provider Organization (PHCS PPO). This extended Provider Network is available to You as Network Benefits only when you are **outside** of Our contracted network. To find a PHCS PPO provider, call Our Customer Contact Center or visit www.phcs.com and select the PPO Network.

PHCS PPO Network is not available when you receive services **within** Mercy Health Plans' contracted network.

Network Benefits

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services that are described as Network Benefits in Section 11 (Covered Benefits) and are any of the following:

- Provided by a Network Physician or other Network Provider.
- Emergency Room Services.

Designated Facilities and Other Providers

If You have a medical condition that We believe needs special services, We may direct You to a Designated Facility or other Network Provider chosen by Us. Network Benefits will only be paid if Your Covered Health Services for that condition are provided by, or arranged by the Network Designated Facility, or other Network Provider chosen by Us. Non-Network Benefits will apply to any Non-Network facility or provider.

Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by Non-Network Physicians or Non-Network Providers.

What You must do to get covered care

You or Your physician must notify Us and obtain Prior Authorization before getting certain Covered Health Services from either Network or Non-Network Providers. However, **You are responsible for ensuring that Your provider obtains any required Prior-Authorization before You receive Covered Health Services.** A current list of those services and supplies requiring Prior Authorization is available by calling Our Customer Contact Center at the telephone number listed on Your ID card, or by visiting www.mercyhealthplans.com. Verify with your Physician, or Our Contact Center, the authorized date range, and the number and type of services.

We urge You to confirm with Us that the services You plan to receive are Covered Health Services. Prior Authorization does not mean Benefits are payable in all cases. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before You receive treatment, You can check to see if the service is subject to limitations or exclusions including, but not limited to:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reconstruction; vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty;
- The Experimental, Investigational or Unproven Services exclusion;
- Any other contract limitation or exclusion.

FAILURE TO PREAUTHORIZE CERTAIN BENEFITS MAY RESULT IN A REDUCTION OF ELIGIBLE EXPENSES.

Care Management

When You notify Us as described above, We will work together to implement the care management process and to provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Room Services

We provide Benefits for Emergency Room Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Services, even if a Non-Network Provider provides the services. Emergency Services and any follow-up care rendered by a Non-Network Provider must be:

1. Of such immediate nature that Your health would be jeopardized if taken to a Network Hospital where the services of a Participating Physician would be available, or
2. Provided under circumstances under which You are unable, due to Your condition, to

request treatment at a location where the services of a Participating Physician would be available.

- If You are admitted as an inpatient to a Network or Non-Network Hospital after You receive Emergency Room Services, We must be notified within two (2) working days or on the same day of admission, or as soon as reasonably possible to receive authorization for continued services. Continuation of care as for any Inpatient Stay requires Prior Authorization and approval by the Plan.
- If You are admitted as an inpatient to a Non-Network Hospital after you receive Emergency Room Services, We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date We decide a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
- If You are admitted as an inpatient to a Network or Non-Network Hospital within twenty-four (24) hours of receiving treatment for the same condition as an Emergency Service, You will not have to pay the Copayment for Emergency Room Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

Urgent Care Services

Covered Health Services that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. Urgent Care is not the same as Emergency Care.

Section 6: Your Cost for Covered Services

This is what You will pay for covered care:

Copayments

A Copayment is a fixed amount of money You pay to the provider, facility, pharmacy, etc., when You receive *certain* services. **Copayments do not count towards Your Out-of-Pocket Maximum or Your Deductible.** Copayment amounts are listed on the Schedule of Coverage and Benefits next to the description for each Covered Health Service.

Coinsurance

Coinsurance is the percentage of Our Eligible Expenses that You must pay for Your care. Coinsurance doesn't begin until after You meet Your Deductible. **Only Coinsurances count toward Your Out-of-Pocket Maximum.**

Deductible

A Deductible is a fixed expense You must incur within a Calendar Yearfor certain Covered Services and supplies before We start paying Benefits for them. For a complete definition of Annual Deductible, see Section 13 (Definitions of Terms).

NOTE: The Network Deductible does not apply to the Non-Network Deductible; also, the Non-Network Deductible does not apply to the Network Deductible.

Deductibles do not apply to Your Out-of-Pocket Maximum.

For Your Annual Deductible see Your Schedule of Coverage and Benefits.

Eligible Expenses

Eligible Expenses are the amount We determine that We will pay for Benefits minus any Copayment, Coinsurance or Deductible. We will pay a contracted rate for Network Providers. For Non-Network Providers, however, We will pay the Usual and Customary Rate (UCR) as determined by Us. For a complete definition of Eligible Expenses and UCR that describes how We determine payment, see Section 13 (Definitions of Terms).

Charges in Excess of the UCR

Charges by a provider in excess of UCR will not be covered under this Policy and will not be counted toward Your Out-Of-Pocket Maximum limit or Deductible.

For Network Benefits, You are not responsible for any difference between the Eligible Expenses and the amount the provider bills, but You are responsible for all Copayments, Coinsurances or Deductibles.

For Non-Network Benefits, You are responsible to pay, directly to the Non-Network Provider, any difference between the amount the provider bills You and the UCR amount We will pay for Eligible Expenses. Please see Section 12 (Exclusions).

Out-of-Pocket Maximum

The maximum You pay out of Your pocket in a CalendarYear for Coinsurances. For a complete definition of Out-of-Pocket Maximum, see Section 13 (Definitions of Terms).

If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that CalendarYear. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that CalendarYear.

The Out-of-Pocket Maximum does not include any of the following:

- Any charges for Non-Covered Health Services;
- Copayments for Covered Health Services available by an optional Rider;
- The amount of any reduced Benefits if You don't obtain Prior Authorization as described in Section 11 (Covered Benefits);
- Charges that exceed Eligible Expenses;
- Any Copayments for Covered Health Services in Section 11 (Covered Benefits);
- The Annual Deductible.

For Your Annual Out-of-Pocket Maximum see Your Schedule of Coverage and Benefits.

Maximum Policy Benefit

The maximum amount We will pay for Benefits during the entire period of time You are enrolled under the Policy. For a complete definition of Maximum Policy Benefit, see Section 13 (Definitions of Terms).

For Your Maximum Policy Benefit see Your Schedule of Coverage and Benefits.

Section 7: How to File a Claim

Network Provider

We pay Network Providers directly for Your Covered Health Services, so Network Providers file claims on Your behalf to us. If a Network Provider bills You for any Covered Health Service, contact Us. However, You are responsible for meeting any Annual Deductible and paying Copayments or Coinsurance to a Network Provider at the time of service or when You receive a bill from the Provider.

Non-Network Provider

When You receive Covered Health Services from a Non-Network Provider, You may be responsible for paying for all expenses up front and then requesting reimbursement from Us.

How to File a Claim

While You do not need to fill out a specific claim form, You must file the claim in a format that contains all of the information We require, as described below.

If a Subscriber provides written authorization to a Non-Network Provider for payment of medical Benefits for any Eligible Expenses, reimbursement may be paid directly to that Provider. If the subscriber did not sign authorization for payment of medical Benefits, the subscriber may be responsible for paying all expenses up front and then requesting reimbursement from Us. We will not reimburse third parties who have purchased or been assigned Benefits by Physicians or other Providers.

Required Information for Claims

When You request payment of Benefits from Us, You must provide Us with all of the following information:

1. The Subscriber's name and address;
2. The patient's name and age;
3. The number stated on Your ID card;
4. The name, address, phone number and Tax ID of the provider of the service(s);
5. A diagnosis from the Physician;
6. An itemized bill from the provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge;
7. The date the Injury or Sickness began;
8. A statement indicating whether You are, or You are not, enrolled for coverage under any other health insurance plan or program. If You are enrolled for other coverage, You must include the name of the other carrier(s), the name and date of birth of the subscriber for that coverage and the effective date of the coverage..

Proof of Loss

Written proof of such loss and notice of claim must be provided to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within such time will neither invalidate nor reduce any claim, if it was not reasonably possible to furnish such proof within such time. In no event, except in the absence of legal capacity of the claimant, will a claim be valid later than one (1) year from the time proof is otherwise required. All Benefits payable under the Policy will be paid within thirty (30) days after receipt of proof. Written proofs of claim must be furnished to the Plan at P.O. Box 4568, Springfield, MO 65808.

Time of Payment of Claims

Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim. All eligible reimbursement will be payable to Providers. We will send You an Explanation of Benefits form or letter. This will show You what services were paid, how much was paid, who was paid, when payment was made, or why payment for some services was not made or was made in part. There may be some circumstances for which We must seek additional information from You to process the claim. We will suspend (pend) the claim for up to thirty (30) days to give You ample time to respond. If You fail to respond within the thirty (30) days, the claim will be denied. If You present the information after the thirty (30) days allocated, the claim will be reprocessed in accordance to the terms and Benefits of Your coverage. If We deny all or any part of Your claim, We will send You an Explanation of Benefits form or a letter telling You why it was denied. The form or letter may also tell You what other information, if any, We

would need to reconsider Our decision. If You do not agree with Our decision, You have the right to appeal Your claim. See Section 8 (Complaints, Grievances and Appeals). You may also call or write Us, or You may contact the Arkansas Insurance Department.

Action on Claims

If a claim is denied, We will send You a written notice that contains the reason for the denial and information on Your right to appeal. If You believe there is a discrepancy between the Benefits, the Policy, and the processing of such claim, or if You have a Grievance, You must notify the Plan no later than one-hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to a Grievance. If a claim is denied, You may obtain a review of the denial through the Complaint and Grievance Procedure. See Section 8 (Complaints, Grievances and Appeals).

Release of Records

During the processing of Your claim, We might need to review Your health records. As a Covered Person, You hereby authorize the release to Us of all health records related to Your claim. This release constitutes authorization of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality under the terms of applicable privacy laws. This authorization also applies to any Covered Dependent under this Policy.

Direct Payment to Public Hospitals

Benefits for Covered Health Services will be paid, with or without an assignment from You, to public hospitals or clinics for services and supplies provided to You, if proper claim is submitted by the public hospital or clinic. No Benefits will be paid under this Section to the public hospital or clinic, if such Benefits have been paid to You prior to Us receiving Your claim. Payment to the public hospital or clinic will discharge Us from all liability to You to the extent of the Benefits so paid.

Section 8: Complaints, Grievances & Appeals

These procedures address all Complaints, Grievances, and appeals from Members concerning operation of the Plan, **except** any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment.

A Member, a Member's authorized representative, or a Provider can make a Complaint or Grievance at any time. Complaints can be about anything, including: the Plan's service, Utilization Review, or a provider's service. A Complaint or Grievance can always be directed to the Arkansas Insurance Department at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
1-800-852-5494

Step	Description

1 **What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.**

Customer Contact Center Representatives are available to take Your call during regular business hours, 8:00 AM – 5:00 PM, Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below.

The Plan agrees to investigate, and endeavor to resolve, any and all Complaints received from Members with regard to the nature of professional services rendered, or Benefits provided, under thisPolicy. Oral complaints or inquiries can be made to the Plan by telephone or an arranged appointment with the Customer Contact Center Representative at:

Mercy Health Plans
ATTN: Customer Contact Center
14528 S. Outer 40, Suite 300
Chesterfield, Missouri 63017-5743
866-450-3249

The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your rightful access to review through the formal Grievance Process.

2 **Ask Us in writing to reconsider Our initial decision.**

Minimum Time to File a Grievance: You must file a Grievance no later than one hundred eighty (180) days from the date that written notice was sent from the Plan, informing You of the event that gave rise to the Grievance.

Grievance Procedure: Ask Us in writing to reconsider Our initial decision. You, Your authorized representative, or Your Provider can submit a Grievance described below.

a) Write to Us no later than one hundred eighty (180) days from the date that written notice was sent from the Plan to You, informing You of the event that gave rise to the Grievance;

b) Send Your request to: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743;

c) Include a statement about why You believe Our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms.

The Plan will acknowledge receipt of Your Grievance in writing within ten (10) working days. A complete investigation of the Grievance will follow. Someone who is neither the individual who made the initial determination, nor the subordinate of such individual will conduct the review.

In the case of a Grievance involving a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual.

We will notify You of Our determination in writing as follows:

- Within thirty (30) calendar days for a service You have not yet received pre-service; or
- Within sixty (60) calendar days for a service You have already received post-service.

This written determination will include information about Your right to request an External Independent Review (if We maintain Our denial of an Adverse Determination) and Your right to other voluntary alternative dispute resolution..

3 ***Expedited Grievance Procedure:*** When the standard time frames of the Grievance procedure would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) working days of the notification of the determination.

4 ***Ask Us for an External Independent Review, only if Your appeal was related to an Adverse Determination.***

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Review. A request for a standard External Review must be made in writing, and should include any information or documentation to support Your request for the covered service. **Note: Only appeals that are related to an Adverse Determination and that involve treatment, services, equipment, supplies, or drugs that would require the Plan to expend $500 or more of expenditures are afforded an External Independent Review.**

"Adverse Determination" means a determination by the Plan that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested health care service does not meet the Plan's requirements for medical necessity, or

(b) The requested health care service has been found to be "Experimental/Investigational."

The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the External Independent Review organization selected to perform the review. For the purposes of this Section, an External Independent Reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the case; and (c) have not been informed of the specific identity of the Member.

The independent review organization will complete its review within forty-five (45) calendar days after the receipt of the request for an External Review and will provide a written notice of its decision to You, or Your authorized representative, and the Plan.

An expedited External Independent Review may be requested for a situation when a delay would significantly increase the risk to Your health or when extended health care services for a course of treatment that You are undergoing is at issue. Upon submission of a request for expedited External Independent Review, the Plan will immediately assign an independent review organization approved by the Arkansas Insurance Department. The independent review organization shall make a determination and verbally notify You, or Your authorized representative, and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the independent reviewer is final. Within two (2) calendar days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

5 At any time, You have the right to contact the Arkansas Insurance Department 's consumer complaint hotline at: **1-800-852-5494** regarding Your grievance, or write to the Arkansas Insurance Department at the following address: **Arkansas Insurance Department, Consumer Services Division, Third and Cross Streets, Little Rock, AR 72201**.

Section 9: Utilization Review

The following is information pertaining to Utilization Review decisions and procedures. Please note that in addition to Utilization Reviews, Mercy Health Plans' practices Care Management, and therefore may provide You with information about additional services that are available to You such as disease management programs, health education, pre-admission counseling and patient advocacy.

Initial Determinations

For initial determinations, the Plan will make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this Section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an admission, procedure or service, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification.

In the case of an Adverse Determination, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the Adverse Determination; and will provide written or electronic confirmation of the telephone notification to You and Your provider within one (1) working day of making the Adverse Determination.

Concurrent Review Determinations

For concurrent review determinations, the Plan will make the determination within one (1) working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, the Plan will notify by telephone the provider rendering the service within one (1) working day of making the certification.

In the case of an Adverse Determination, the Plan will notify by telephone the provider rendering the services within twenty-four (24) hours of making the Adverse Determination, and provide written or electronic notification to You and Your provider within one (1) working day of the telephone notification.

Retrospective Review Determinations

For retrospective review determinations, the Plan will make the determination within thirty (30) working days of receiving all necessary information. The Plan will provide notice in writing of Our determination to You within ten (10) working days of making the determination.

Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. The Plan will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination, to any party who received notice of the Adverse Determination, and who requests such information.

Reconsideration of an Adverse Determination

In a case involving an initial determination or a concurrent review determination, the Plan will give the provider rendering the service an opportunity to request, on Your behalf, a reconsideration of an Adverse Determination by the reviewer making the Adverse Determination.

The reconsideration will occur within one (1) working day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the Adverse Determination, or a clinical peer designated by the reviewer who made the Adverse Determination (if the reviewer who made the Adverse Determination is not available within one (1) working day).

If the reconsideration process does not resolve the difference of opinion, You or Your provider may appeal the Adverse Determination. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an Adverse Determination.

Lack of Information

The Plan will have written procedures to address failure or inability of a provider or an enrollee to provide all necessary Information for review. In cases where the provider or an enrollee will not release necessary information, the Plan may deny certification of an admission, procedure or service.

Complaint and Grievance Procedures

These procedures address all Complaints, Grievances, and appeals concerning operation of Mercy Health Plans except any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment. The Complaint procedure is more fully described in Section 8 (Complaints, Grievances and Appeals).

Section 10: General Provisions

Your Relationship with Us

In order to make choices about Your health care coverage and treatment, We believe that it is important for You to understand how We interact with You. We help finance and administer the benefit plan in which You are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to You decisions about whether Your benefit plan will cover or pay for the health care that You may receive. The plan pays for certain medical costs, which are more fully described in this Policy. The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.
- We do not decide what care You need or will receive. You and Your Physician make those decisions.

We may use individually identifiable information about You to share with You (and You alone) procedures, products or services that You may find valuable. We will use individually identifiable information about You as permitted or required by law, in Our operations and in Our research. We will use de-identified data for commercial purposes, including research.

Our Relationship with You

The relationship between You and the Plan is solely a contractual relationship between independent contractors. You are not Our agent or employee. Neither We nor any of Our employees are Your agents.

We do not provide Health Care Services or supplies, nor do We practice medicine. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of Benefits under Your benefit plan.

You are solely responsible for all of the following:

- Enrollment changes (including the termination of Your coverage).
- The timely payment of the required Premium to Us.

Your Relationship with Providers

The relationship between You and any provider is that of provider and patient;

- You are responsible for choosing Your own provider;
- You must decide if any provider treating You is right for You. This includes providers You choose and providers to whom You have been referred;

- You must decide with Your provider what care You should receive;
- Your provider is solely responsible for the quality of the services provided to You.

Administrative Services

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Our sole discretion. We are not required to give You prior notice of any such change, nor are We required to obtain Your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, We reserve the right, in Our sole discretion and without Your approval, to change, interpret, modify, withdraw or add Benefits, or terminate the Policy.

Any provision of the Policy that on its Effective Date is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy, unless it is made by an Amendment or Rider that has been signed by one of Our officers. All of the following conditions apply:

- Amendments to the Policy are effective thirty-one (31) days after We send a written notice to the Enrolling Individual.
- Riders are effective on the date We specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Assignment

This Policy and all the rights, responsibilities and benefit payments under it are personal to You. You may assign them to any Provider of Covered Service.

Case Management

Case Management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family, and the attending physician to determine appropriate treatment options that will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation, or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to You or Your Dependent. In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive You of Benefits under the Policy, nor will it create a right to Benefits. If the Enrolling Individual makes a clerical error (including, but not limited to, sending Us inaccurate information regarding Your enrollment for coverage or the termination of Your coverage under the Policy) We will not make retroactive adjustments beyond a 60-day time period unless we are at fault. Our clerical errors or delays in keeping or reporting data relative to coverage will not terminate coverage which would otherwise be in force, nor continue coverage which would otherwise be terminated. Upon discovery of errors or delays, We will make whatever change is needed to assure that You have the coverage to which You are entitled to. No retroactive coverage or Premium changes will be made unless prior written approval is received from Us.

Conformity with State Laws

If any provision(s) of this Policy conflicts with Arkansas law, then those provision(s) are automatically changed to conform to at least the minimum requirements of the law.

Commission or Omission

No Hospital, Physician or other Provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other Providers or services or their agent or employee; or (4) You.

Entire Policy/Changes

The Policy issued to You, Your application, Amendments and any applicable Riders constitute the entire Policy. No change in this Policy will be valid until approved by one of Our executive officers, and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Examination of Covered Persons

In the event of a question or dispute regarding Your right to Benefits, We may require that a Network Physician of Our choice

examine You at Our expense.

Incentives to Providers

We pay certain providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect Your access to health care.

Examples of financial incentives for providers are bonuses for performance based on factors that may include quality, Member satisfaction, and/or cost effectiveness.

We use various payment methods to pay specific providers. From time to time, the payment method may change. If You have questions about whether Your provider has a contract with Us and if that contract includes any financial incentives, We encourage You to discuss those questions with Your provider.

Incentives to You

Sometimes We may offer coupons or other incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is Yours alone, but We recommend that You discuss participating in such programs with Your Physician. These incentives are not Benefits and do not alter or affect Your Benefits. Contact Us if You have any questions.

Incorporation by Reference

Unless otherwise stated herein, the Schedule of Coverage and Benefits, the schedule of rates and Premiums, any riders, the application, and any amendments to any of the foregoing, form a part of this Policy as if fully incorporated herein.

Information and Records

At times, We may need additional information from You. You agree to furnish Us with all information and proofs that We may reasonably require regarding any matters pertaining to the Policy. If You do not provide this information when requested, We may delay or deny payment of Your Benefits.

By accepting Benefits under the Policy, You authorize and direct any person or institution that has provided services to You to furnish Us with all information or copies of records relating to the services provided to You. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents, whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning Health Care Services that are necessary to implement and administer the terms of the Policy for appropriate medical review, quality assessment, or as We are required to do by law or regulation. During and after the term of the Policy, We and Our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of Your medical records or billing statements, We recommend that You contact Your health care provider. Providers may charge You reasonable fees to cover their costs for providing records or completing requested forms.

If You request medical forms or records from Us, We also may charge You reasonable fees to cover costs for completing the forms or providing the records.

In some cases, We will designate other persons or entities to request records or information from or related to You, and to release those records as necessary. Our designees have the same rights to this information as We have.

Interpretation of Eligibility and Benefits

We have sole discretion to do all of the following:

- Determine eligibility;

- Interpret Benefits under the Policy;
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this Policy and any Riders and Amendments;
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case shall not in any way be deemed to require Us to do so in other similar cases.

Legal Actions

You may not bring any action of law or in equity concerning a claims payment until sixty (60) days after written proof of claim for Benefit payment has been furnished to Us, in accordance with the requirements of the Policy. Any such action must be filed within three (3) years of the date a claim is required to be sent to Us.

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Covered Persons who are eligible for or enrolled in Medicare may NOT be covered under the Policy.

Misstatement of Age

If the age of the insured has been misstated, all amounts payable under this Policy shall be equal to the amount that the Premium paid would have purchased at the actual age when the policy was issued.

Notice

When We provide written notice regarding administration of the Policy to Your authorized representative, that notice is deemed notice to You and Your Enrolled Dependents.

Any notice required under this Policy will be sufficient if it is in writing, and mailed or delivered:

a) To You, when addressed to You at the address currently appearing on Our records; or
b) To Mercy Health Plans, when addressed to 14528 S Outer 40, Suite 300, Chesterfield, Missouri 63017-5743.

Policies, Identification Cards and Applications

We will furnish You with identification cards, copies of this Policy, and applications.

Reimbursement to Us

a) As a Covered Person, You agree to refund Us any benefit payment We made to You, or on Your behalf, for a claim paid or payable under Workers' Compensation or employers' liability law. Even if You fail to claim through a Workers' Compensation or employers' liability law, and You could have received payment through such a law if You had filed, reimbursement must still be made to Us. We have the right to credit payments of such claims against future claims in all cases.

b) We have the right to correct benefit payments paid in error. Hospitals, Physicians, other Providers and/or You have the responsibility to return any overpayment, including claims made involving fraud to Us. We have the responsibility to make additional payment if an underpayment is made.

Right of Reimbursement

In consideration of the coverage provided by this Certificate of Coverage, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us,
  - Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - Responding to requests for information about any accident or injuries,
  - Making court appearances, and
  - Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

Statements by Enrolling Individual or Subscriber

Except for fraudulent statements, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits, unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary.

Time Limit on Certain Defenses

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for charges incurred after the expiration of such three (3) year period.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by Workers' Compensation insurance.

Section 11: Covered Benefits

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
1. Ambulance Services- Emergency only	Medically Necessary ambulance service (either by a licensed ambulance service - ground or air ambulance) to the most appropriate Hospital where Emergency Care can be provided in the case of a Medical Condition and Medically Necessary transportation, however, use of air ambulance must be approved in advance or as soon as reasonably possible by the Plan. Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in emergency situations. See Section 12, R., for related exclusions.
2. Dental-Anesthesia and Facility Charges	Administration of general anesthesia and Hospital charges for dental care if: • The Covered Person is a child under the age of seven (7) who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or • The Covered Person is diagnosed with a serious mental or physical condition; or • The Covered Person has a significant behavioral problem as determined by the Plan. Limitations and Exclusions are described in Section 12, D. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits for dental anesthesia and related facility charges will be reduced by 50% of Eligible Expenses.
3. Diabetes Services	Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes. Coverage is provided for insulin infusion devices, insulin pumps, and associated supplies. Services for **diabetes self-management training**: Covered Health Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a licensed physician and a licensed health care professional must certify that the Covered Person successfully completed the training program. Coverage is limited to one(1) program during the entire time a Covered Person is Covered under this Certificate. A provider licensed, registered, and/or certified in the state to provide appropriate Health Care Services must provide diabetes self-management training program. Training is to be provided upon the initial diagnosis of diabetes, when there is a significant change in the Member's symptoms or when the Food and Drug Administration for the treatment of diabetes approve new techniques and treatments. **Prior Authorization Required** You must obtain Prior Authorization before receiving services for the following: ▪ Insulin pumps Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
4. Emergency Room Services	Emergency Room Services that are required to stabilize or initiate treatment in an Emergency. Emergency Room Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Room Services in Section 5 (How You

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Get Care). Physician charges may be applicable, if billed separately. See *Professional Fees for Surgical and Medical Services* below. Please remember that if You are admitted to a Hospital as a result of an Emergency, You must notify Us within two (2) working days or the same day of admission, or as soon as reasonably possible to receive authorization for continued services related to post-stabilization, as needed. If You don't notify Us, Benefits for the Hospital Inpatient Stay will be reduced to by 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services. Please refer to Hospital – Inpatient Stay below. If an Emergency Room admission results in a conversion to an Inpatient Stay or Observation Care, the Emergency room Copayment/Coinsurance charge will be waived when the hospital inpatient or observation admission for the same condition occurs within twenty-four (24) hours. The alternate higher level Copayment/Coinsurance will apply.
5. Hearing Screenings for Newborns	Newborn hearing screenings, necessary re-screening, audiological assessment and follow-up, and initial amplification.
6. Immunization – Routine Only	Routine immunizations as defined by the Plan. Coverage limitations may apply. Immunizations required for international travel are excluded. A list of routine immunizations can be obtained at **www.mercyhealthplans.com** or by calling Our Customer Contact Center at the number listed on Your ID card. There is no Copayment, Coinsurance or Deductible for routine immunizations. Applicable Copayments for office visit will apply. All other preventive health care services will be subject to Copayment, Coinsurance, Deductible, or dollar limit provisions.
7. Inpatient Hospital Services	Inpatient Hospital Services are available for: • Services and supplies received during the Inpatient stay. • Room and board in a Semi-private Room (a room with two or more beds), or • A private room only when medically necessary and approved in advance by the Plan. **Prior Authorization Required** Please remember that You must notify Us as follows: • For elective admissions; and • For Emergency admissions: within two (2) working days or the same day of admission, or as soon as is reasonably possible. Unless We pre-approve inpatient Hospital services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
8. In-Vitro Fertilization Services	Covered Health Services for In-Vitro Fertilization (IVF) include the following charges: • IVF associated lab; • Medication; • Imaging and procedures including female and male pre-testing; • The IVF process, and;

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	• Cryopreservation. Benefits are provided for in-vitro fertilization if the following conditions are met: • The patient's oocytes are fertilized with the sperm of the patient's Spouse, and • The patient and the patient's Spouse have a history of unexplained infertility of at least two (2) years' duration; or • The infertility is associated with one or more of the following medical conditions: • Endometriosis; • Exposure in utero to Diethylstilbestrol, commonly known as DES; • Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or • Abnormal male factors contributing to the infertility, and • The in-vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization. Any combination of Network and Non-Network Benefits is limited to a lifetime maximum benefit of $15,000 during the entire period of time You are covered under the Policy. **<u>Prior Authorization Required</u>** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
9. Maternity Services	Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any related complications. Sonograms in uncomplicated pregnancies are limited to two per pregnancy. We will pay Benefits for an Inpatient Stay of: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean Section delivery. • 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Early discharge requires that both of the following requirements are met: • The discharge complies with the guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. • The mother and child are provided post-discharge care as determined by the attending physician. Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician; and includes parent education, training in breast or bottle-feeding, and appropriate testing of the mother and child. Copayments and Deductible requirements apply to normal newborn admissions and both the mother and newborn will incur separate inpatient Copayments/Deductibles as follows: • If the mother and newborn are discharged from the same hospital on the same day, applicable Copayments/Coinsurances and Deductible will apply separately for the mother and the newborn; however, the Deductible will be waived for the newborn;

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	• If the mother and newborn are *not* discharged from the same hospital on the same day, both the mother and newborn will each incur applicable Copayments/Coinsurances and Deductibles for their inpatient hospital stay. The newborn's inpatient hospital Copayment/Coinsurance and Deductible will cover the dates of service *after* the mother's discharge, or dates of service at a different hospital. • If the newborn remains hospitalized after the mother's discharge date, an inpatient authorization is required for the dates of service after the mother's discharge date, and vice versa. See "Prior Authorization Required" below. **Note: The number of prenatal visits or change in Physician may effect Your Copayment/Coinsurance.** **Prior Authorization Required** Please remember that You must notify Us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. Unless We pre-approve any extended inpatient Hospital services beyond labor and delivery for either You or Your newborn, Your Network and Non-Network Benefits for the extended stay will be reduced by 50% of Eligible Benefits.
10. Newborn Child Coverage	Coverage for newborn children begins from the moment of birth. Benefits include coverage for illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, all other disorders of metabolism, and routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period. **Prior Authorization Required** We must be notified within ninety (90) days of birth, or Your next Premium due date, whichever is greater. If You don't notify Us, You will be responsible for paying 100% charges incurred after the lesser of five (5) days, or the mother's discharge date.
11. Observation Care	Observation Care are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services do not exceed one (1) day. Members may be admitted as Observation status to beds in the Emergency room, an observation unit, the intensive care unit, or a regular floor. If an Observation admission results in a conversion to an Inpatient Admission for the same condition within twenty (24) hours, the Observation Copayment will be waived. The alternate Copayment/Coinsurance will apply. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
12. Osteoporosis Services/Bone Mineral Density (BMD) Testing	Diagnosis, treatment, and appropriate management of osteoporosis for Covered Persons with a condition or medical history for which bone mass measurement is medically indicated. Coverage limitations may apply. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Prior Authorization Required Unless We pre-approve services requiring Prior Authorization, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
13. Outpatient Diagnostic Services	Covered Health Services received on an outpatient basis at a Hospital or Alernate Facility for laboratory and medical diagnostic services. • Laboratory servies; • X-ray/imaging services; • Other diagnostic tests and therapeutic treatments (including cancer Chemotherapy or intravenous infusion therapy). The following services are subject to the outpatient diagnostic charges regardless of the place of service: • MRA • MRI • CT Scan • PET Scan • Nuclear Cardiology Imaging studies Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on your ID card. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
14. Outpatient Surgery/Hospital Procedures	Covered surgical services and other medical care received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this Section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below, and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment. **Surgical Implants**, whether inserted in the inpatient, outpatient, or office setting, including pacemakers, stents, and other implantable devices or treatments. Copayment is consistent with type of service required. Implants for cosmetic or psychological reasons are excluded, see Section 12, L. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on your ID card. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
15. Physician's Office Services	Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury; • Preventive medical care; • Well-baby and well-child care including children's preventive health care services for children from birth through eighteen (18) years of age; • Routine physical examinations.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
16. PKU/Medical Foods and Low Protein Modified Food Products for Metabolic Disorders	Benefits are provided for Medical Foods and Low Protein Modified Food Products for Metabolic Disorders if the following are met: • The Medical Food or Low Protein Modified Food Products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; • The products are administered under the direction of a licensed physician; and • The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the $2,400 per year per person. See Section 12, J. for limitations and exclusions related to this benefit.
17. Preventive Health & Wellness Care	Preventive Health Screenings are for non-symptomatic persons in accordance with the American Cancer Society guidelines and Mercy Health Plans' preventive health guidelines. Preventive Health Screenings include one (1) routine test of each of the following every Calendar Year, unless otherwise indicated: • Cholesterol Tests • Colon Screening: – Colonoscopy – one (1) routine screening every ten (10) years – Double-contrast Barium Enema – one (1) routine screening every five (5) years – Flexible Sigmoidoscopy – one (1) routine screening every five (5) years – Fecal Occult Blood Test • Mammography • Pap Test • Pelvic Exam • Prostate Exam • PSA test [Preventive Health Screenings are covered in-Network with no Deductible. Deductible and Coinsurances will apply to services received from a Non-Network Provider.]
18. Professional Fees for Surgical and Medical Services	Professional fees for surgical procedures and other medical care provided in an outpatient facility. You may incur a separate copayment/coinsurance in addition to the outpatient facility charge. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.
19. Reconstructive Procedures	Services for reconstructive procedures, when a physical impairment exists, and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. See Section 12, L. for related limitations and exclusions. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast disease, and reconstruction of the Non-affected breast to achieve symmetry.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Reconstructive surgery for breast reconstruction and the receipt of a related prosthetic devices may follow a mastectomy at any time. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at the telephone number on Your ID card for more information about Benefits for mastectomy-related services. **Prior Authorization Required** You must notify Us before receiving services. When You notify Us, We can verify that the service is a reconstructive procedure, rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. Unless We pre-approve a Covered reconstructive Service, Network and Non-Network Benefits for reconstructive procedures will be reduced by 100% of Eligible Expenses.
20. Rehabilitation Services	***Outpatient Rehabilitation Therapy:*** Short-term outpatient rehabilitation services for: • Physical Therapy; • Occupational Therapy; • Speech Therapy; • Pulmonary Rehabilitation Therapy; • Cardiac Rehabilitation Therapy. Also includes covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for treatment for loss or impairment of speech or hearing. "Short-term" means rehabilitation services that are expected to result in significant physical improvement in Your condition within two (2) months of the start of treatment. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Home rehabilitation services are limited to the Homebound patient and considered separately under the home health Benefit. Please note that We will pay Benefits for Speech Therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Rehabilitation therapy services that are considered maintenance, developmental or educational in nature are not covered Benefits. Exclusions are described in Section 12, P. Any combination of Network and Non-Network Benefits is limited as according to Your Schedule of Coverage and Benefits. ***Inpatient Rehabilitation Services:*** Medically Necessary services for an Inpatient Stay in an Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-Private Room Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or non-elective inpatient rehabilitation admission. Unless We pre-approve inpatient rehabilitation services, Network and Non-Network Benefits will be reduced by

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	50% of Eligible Expenses. For emergency admission, You must notify Us within two (2) working days or as soon as reasonably possible.
21. Skilled Nursing Facility (SNF)	Medically Necessary services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay; • Room and board in a Semi-private Room. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or Non-elective admission. Unless we pre-approve SNF services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For emergency admissions, You must notify Us with two (2) working days or as soon as reasonably possible.
22. Urgent Care Center Services	Covered Health Services received at an Urgent Care Center. If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this Section.

Section 12: Exclusions – Things We Don't Cover

This Section contains information about Medical services that are not covered. We call these Exclusions. It's important for You to know what services and supplies are not covered under the Policy.

We do not pay Benefits for exclusions or any related complications.

We will not pay Benefits for any of the services, treatments, items or supplies described in this Section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for Your condition.

The services, treatments, items or supplies listed in this Section are not Covered Health Services, except as may be specifically provided for in Section 11 (Covered Benefits) or through a Rider to the Policy.

Category	Description
A. Allergy	We do not cover any allergy related injections and serum, treatment, or testing.
B. Alternative Treatments	We do not cover alternative treatments, including but not limited to: 1. Acupressure and Acupuncture. 2. Aromatherapy. 3. Hypnotism. 4. Massage Therapy. 5. Rolfing. 6. Herbal remedies. 7. Ayurvedic therapies. 8. Reflexology. 9. Biofeedback and neurofeedback therapy. 10. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
C. Comfort or Convenience	1. Television. 2. Telephone. 3. Beauty/Barber service. 4. Guest service. 5. Automated travel devices (motor scooters). 6. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include: - Air conditioners - Air purifiers and filters - Batteries and battery chargers - Dehumidifiers and Humidifiers - Electrostatic machines - Lights/lighting - Portable room heaters, grab bars, etc. - Vaporizers - Tanning booths - Bath chairs - Breast pumps, unless newborn in NICU - Exercise equipment - Raised or regular toilet seats - Whirlpools, saunas, and hot tubs 7. Devices and computers to assist in communication and speech. Augmentative communication devices, including, but not limited to, computer assisted speech devices, speech teaching machines, telephones, TDD equipment, Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, Non-digital voice systems, such as the Electro-Larynx, after post-radical neck or other invasive surgery that interferes with laryngeal function. 8. Personal hygiene items and hygienic items, including, but not limited to, shower chairs, commodes (unless the individual is confined to room or bed), incontinence pads, bed baths, etc. 9. Devices that are primarily non-medical in nature or used primarily for comfort,

Category	Description
	including, but not limited to: - Bed boards - Elevators - Foam pads - Heating pads - Beds other than standard single hospital beds - Overbed tables - Carafes - Emesis basins - Maternity belts - Bathtub seats - Standing tables 10. Chair lifts, bathtub lifts, bed lifter, and other similar devices. 11. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.
D. Dental	1. Dental care, including Accidental Dental, except as described in Section 12 (Covered Benefits) under the heading, "Dental – Anesthesia and Facility Charges". 2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following: – Extraction, restoration and replacement of teeth; – Medical or surgical treatments of dental conditions; – Services to improve dental clinical outcomes; – Services for overbite or underbite; – Services related to surgery for cutting through the lower or upper jaw bone; – Maxillary and mandibulary osteotomies 3. Dental implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded. 4. Dental braces and occlusal splints, even if associated with Accidental Dental Services. 5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: – Transplant preparation; – Initiation of immunosuppressives; – The direct treatment of acute traumatic Injury; – The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment); – Cleft palate; – Covered Persons with conditions outlined in Section 11 (Covered Benefits) under Dental – Anesthesia and Facility Charges; 6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly. 7. Orthodontic services. 8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. 9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer. 10. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint syndrome, except as a treatment of obstructive sleep apnea.
E. Drugs	1. Prescription drug products for outpatient use (including self-injectables) that are filled by a prescription order or refill. 2. Non-injectable medications given in a Physician's office except as required in an Emergency. 3. Over the counter drugs and treatments. 4. Charges for supplies for use beyond the first twenty-four (24) hours following

Category	Description
	discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any prescription drugs intended primarily for home use. 5. Injectables/Infusions provided in a Physician's office, infusion center or through home health.
F. Experimental, Investigational or Unproven Services	1. Experimental, Investigational or Unproven Services are excluded including routine patient care costs for phase II, III or IV of clinical trials undertaken for the purpose of the prevention, early detection and treatment of cancer. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
G. Foot Care	1. Routine foot care (including the cutting or removal of corns and calluses). 2. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection. 3. Hygienic and preventive maintenance foot care. Examples include the following: – Cleaning and soaking the feet; – Applying skin creams in order to maintain skin tone; and – Other services that are performed when there is not a localized illness, Injury or symptom involving the foot. 4. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet, unless otherwise noted in this document. 5. Treatment of subluxation of the foot. 6. Shoe orthotics, orthopedic shoes and other supportive appliances for feet**.**
H. Medical Supplies and Appliances	1. Devices used specifically as safety items or to affect performance in sports-related activities. 2. Prescribed or Non-prescribed medical supplies and disposable supplies. Examples include: – Elastic stockings – Ace bandages – Gauze and dressings – Disposable sheets and bags – Fabric supports – Surgical face masks – Incontinent pads, including diapers – Irrigating kits – Pressure leotards – Surgical leggings and support hose Exceptions include diabetic supplies. 3. All orthotic and prosthetic devices/equipment except for breast prosthetics following a mastectomy. 4. Tubings and masks. 5. Devices and equipment that are not normally appropriate outside of a hospital (or other provider) setting, including, but not limited to: – Home monitoring devices and supplies, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders) – Home prenatal monitoring and associated nursing support 6. Lift Seats. 7. DME is not covered except for Diabetes Services related equipment as described in Section 11 (Covered Benefits).
I. Mental Health/Substance Abuse	1. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders. 2. Psychosurgery.

Category	Description
	3. Vagus nerve stimulation (VNS) for depression. 4. Residential treatment services.
J. Nutrition	1. Megavitamin and nutrition based therapy (for any purpose). 2. Vitamins (other than those prenatal vitamins prescribed for a Member who is then pregnant). 3. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except for treatment of Diabetes only. 4. Medical foods and other nutritional and electrolyte supplements taken orally, parenterally or enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any inherited disease of amino or organic acids. 5. Nutritional Supplements when tube feeding is the sole source of nutrition is also excluded.
K. Personal	1. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: a. Required solely for purposes of career, education, sports or camp, travel, recreation, employment, insurance, marriage or adoption. b. Related to judicial or administrative proceedings or orders. c. Conducted for purposes of medical research. d. Required to obtain or maintain a license of any type. 2. Custodial Care. See Section 13 (Definitions of Terms). *3*. Domiciliary care or any nursing care on full-time basis in Your home. 4. Private Duty Nursing. See Section 13 (Definitions of Terms). 5. Respite care. 6. Rest cures. 7. Medical and surgical treatment of excessive sweating (hyperhidrosis). 8. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. 9. Oral appliances for snoring. 10. Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony. 11. Work place evaluations and work hardening treatment. 12. Home Health Care Services. 13. Hospice/Pallative Care. 14. Tobacco Cessation education program and products. 15. Dialysis.
L. Physical Appearance	1. Cosmetic Procedures. See the definition in Section 13 (Definitions of Terms). Examples include: – Pharmacological regimens, nutritional procedures or treatments. – Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). – Skin abrasion procedures performed as a treatment for acne. – Liposuction. – Hair transplant for baldness. – Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears. – All other cosmetic services **except** if medically necessary to: i. Repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan; ii. Restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Member under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of normal human variation; or iii. Reconstructive breast surgery performed post-mastectomy. 2. Replacement of an existing breast implant, if the earlier breast implant was performed

Category	Description
	as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 11 (Covered Benefits). 3. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. 4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. 5. Wigs, regardless of the reason for the hair loss except as otherwise provided by law. 6. Treatment of benign gynecomastia (abnormal breast enlargement in males). 7. Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office visits associated with any weight loss program. 8. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded. 9. Sex transformation operations. 10. Breast Reduction Surgery (Reduction Mammoplasty).
M. Providers	1. Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. 2. Services performed by a provider with Your same legal residence. 3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who *is* an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider: a. Has not been actively involved in Your medical care prior to ordering the service, or b. Is not actively involved in Your medical care after the service is received. This exclusion does not apply to mammography testing. 4. Charges Incurred for broken appointments with a Participating Physician.
N. Reproduction	1. Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy. 2. Surrogate parenting. 3. Voluntary sterilization or the reversal of voluntary sterilization. 4. Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother. 5. Contraceptive supplies and services 6. Fetal reduction surgery. 7. Health services associated with the use of Non-surgical or drug induced Pregnancy termination. 8. Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function, unless otherwise covered in this Policy.

Category	Description
O. Services Provided under Another Plan	1. Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. 2. Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by Workers' Compensation or similar law. If coverage under Workers' Compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under Workers' Compensation or similar legislation, if that coverage had been elected. 3. Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage, and facilities are reasonably available to You. 4. Health services while on active military duty. Upon notifying Mercy Health Plans of entry into military service, any pro-rata unearned premiums shall be refunded. 5. Injury or Illness incurred while incarcerated in any local, municipal, state or Federal facility.
P. Therapies/Psychological Testing	1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin (unless otherwise covered under this Policy, or by law). Speech Therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Cognitive therapy. 3. Psychological testing for any reason. 4. Neuropsychological Testing for any reason. 5. All Educational Services, including treatment of learning disorders and acquired cognitive deficits. 6. Water exercise and other exercises not under the supervision of a physical therapist. 7. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 8. Therapy for conditions such as developmental delay, ADHD, and autism.
Q. Transplants	1. Health services for organ and tissue transplants. 2. Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. 3. Health services for transplants involving mechanical or animal organs.
R. Travel	1. Health services provided in a foreign country, unless required as Emergency Care Services. 2. Travel or transportation expenses, even though prescribed by a Physician, except for medically necessary ambulance services. 3. Air ambulance services outside the continental United States for any reason.
S. Vision and Hearing	1. Purchase cost of eye glasses, contact lenses (except for eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a $300.00 dollar benefit per lifetime), or hearing aids. 2. Fitting charge for hearing aids, eye glasses or contact lenses. 3. Eye exercise therapy (orthoptics or pleoptic training). 4. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery. 5. Routine eye examination by an ophthalmologist or optometrist for the correction of refractive errors.

Category	Description
T. General/ Administrative	1. Health services and supplies that are not included in Section 11 (Covered Benefits), or that do not meet the definition of a Covered Health Service - see the definition in Section 13 (Definitions of Terms). 2. Health services received as a result of any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country. 3. Health services received after the date Your coverage under the Policy ends, including health services for medical conditions arising before the date Your coverage under the Policy ends. 4. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. 5. Charges in excess of the Usual and Customary Rate (UCR) or in excess of any specified limitation. 6. Complications of Health Care Services that are not Covered Health Services. 7. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan. 8. Autopsies (post-mortem exams).

Section 13: Definitions of Terms

Adverse Determination A decision by Mercy Health Plans that an admission, availability of care or continued stay has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness leading to a decision that coverage for the requested service is denied, reduced or terminated.

Alternate Facility A health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

Amendment Any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible/Deductible If applicable, the amount You must pay for Covered Health Services in a [Calendar] [Plan] Year before We will begin paying for Benefits in that [Calendar] [Plan] Year. Deductible amounts are separate from and not reduced by Copayments. Deductible and Copayments are in addition to any Coinsurance You pay.

Benefits Your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this Policy of Coverage and any attached Riders and Amendments.

Calendar Year January 1 through December 31 of the same year.

Cardiac Rehabilitation A comprehensive program to rehabilitate the heart.

Case Management A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health Conditions. Case Management may include:

1. Assessment of Your individual benefit needs;
2. Formulation and modification of a comprehensive benefit plan of action;
3. Coordination of Benefits;
4. Evaluation of the effectiveness of the plan of action; and
5. Negotiation of extra-contractual services, if necessary.

Certificate of Coverage This document including all Riders, Amendments and Schedule of Coverage.

Chemotherapy Treatment of disease by FDA-approved antineoplastic agents.

Coinsurance Coinsurance is the percentage of Our allowance that You must pay for Your care. You may also be responsible for other costs for Your care such as a Deductible. See Section 6 (Your Cost for Covered Services).

Complications of Pregnancy Any complications associated with Pregnancy, i.e., conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest period during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Congenital Anomaly

A physical developmental defect that is present at birth, and is identified within the first twelve (12) months of birth.

Copayment

A Copayment is a fixed amount of money You pay when You receive Covered Services. See SSection 6 (Your Cost for Covered Services).

Cosmetic Procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Us.

Covered Health Service(s)/Covered Services

A Covered Health Service is a Health Care Service or supply which is not excluded under Section 12 (Exclusions) and meets the following conditions:

1) Prescribed by a Physician for the therapeutic treatment of Injury, Illness or Complications of Pregnancy;
2) Deemed Medically Necessary and appropriate in type, level, setting, and length of service; and if required by the Plan, is authorized on a prospective and timely basis by the Plan's Medical Director.
3) Rendered in accordance with generally accepted medical practice and professionally recognized standards;
4) Provided on or after the Effective Date and before Your coverage terminates in accordance with Section 4 (When Coverage Ends) and at a time when You met all applicable requirements for eligibility set forth in Section 3 (When Coverage Begins).

Covered Person

Either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "You" and "Your" throughout this Policy are references to a Covered Person.

Custodial Care

Services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent

The Subscriber's legal Spouse or an unmarried Dependent child of the Subscriber. The term child includes any of the following:

- A natural child;
- A stepchild;
- A legally adopted child;
- A child placed for adoption;
- A child for whom permanent legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse.

To be eligible for coverage under the Policy, a Dependent's domicile and his/her primary residence must be in Arkansas. The definition of Dependent is subject to these conditions and limitations:

- A Dependent includes any unmarried dependent child under 19 years of age;
- A Dependent includes an unmarried dependent child who is 19 years of age or older to [23 – 25] years of age, only if You furnish evidence upon Our request, satisfactory to Us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.

A Dependent also includes a child for whom health care coverage is required through a

'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Individual is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility

A Hospital that We name as a Designated Facility. A Designated Facility has entered into an agreement with Us, or with an organization contracting on Our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within Our geographic area.

Durable Medical Equipment (DME)

Medical equipment that is all of the following:

- Can withstand repeated use;
- Is not disposable;
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Is generally not useful to individuals in the absence of a Sickness, Injury or their symptoms;
- Is appropriate for use in the home.

Eligible Expenses

The amount We will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

Eligible Expenses are determined solely in accordance with Our reimbursement policy guidelines. We develop Our reimbursement policy guidelines, in Our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications.
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that We accept.

Eligible Person

An Eligible Person is a Subscriber or Dependent that was covered under the [group] Policy this conversion Policy replaces on the date of termination of such group Policy. An Eligible Person's domicile and his/her primary residence must be located within Arkansas. In addition, an Eligible person is not/cannot be covered by Medicare, or by another health insurance policy, whether individual or group, or by similar benefits provided by any state or federal law.

Emergency

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but will not be limited to, any of the following:

- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain;
- With respect to a pregnant woman who is having contractions, either of the following:
  - Inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery;
  - The transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Care/Emergency Room Services

Health Care Services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent A Dependent who is properly enrolled under the Policy.

Enrolling Individual The individual to whom the Policy is issued.

Experimental or Investigational Services Medical, surgical, diagnostic, psychiatric, substance abuse or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

External Independent Reviewer A clinical peer with no direct financial interest in connection with the Grievance/appeal in question and who has not been informed of the specific identity of the Enrollee.

External Review A process, independent of all affected parties, to determine if a Health Care Service is medically necessary or Experimental/Investigational.

Full-Time Student An unmarried dependent child who is between the ages of 19 – 23 that meets all the following conditions:

- The child must not be regularly employed on a full-time basis;
- The child must be primarily dependent upon the Subscriber for support and maintenance;
- The child must be attending, fulltime, a recognized course of study or training at one of the following:
  - An accredited high school;
  - An accredited college or university;
  - A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student on the date You graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If You do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Grievance A written Complaint submitted by or on behalf of a Member regarding the a) availability, delivery or quality of Health Care Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; b) claims payment, handling or reimbursement for Health Care Services; or c) matters pertaining to the contractual relationship between a Member and the Company.

Health Care Service(s) Those health services provided for cosmetic or other non-medical purposes, or for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

Homebound Homebound means an individual who is confined to the home as a result of their physical or mental condition and that leaving home is a major effort and normally requires assistance. Leaving home is done to receive medical care or for short, infrequent non-medical reasons such as a trip to the grocery store, beauty parlor or barbershop, or to attend religious services.

Hospital A legally constituted institution, having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facilities are operated as a separate institution by a hospital.

Implant(s) That which is implanted such as a piece of tissue, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purpose. Examples of surgical Implants include stents, artificial joints, shunts, grafts pins, plates, screws, anchors and radioactive seeds.

Infertility The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful Pregnancy. (Sexual intercourse means the sexual union between a male and female). Infertility does not include individuals unable to conceive post sterilization.

Initial Enrollment Period The initial period of time, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Low Protein Modified Food Products Food products specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Maximum Policy Benefit The maximum amount that We will pay for Benefits during the entire period of time that You are enrolled under the Policy issued to the Enrolling Individual. The Maximum Policy Benefit includes any amount that We have paid for Benefits under a former Policy issued to the Enrolling Individual that is replaced by the current Policy, as well as any amount that We may pay under a later Policy that replaces the Enrolling Individual's current Policy. When the Maximum Policy Benefit applies, it is described in Section 6 (Your Cost for Covered Services).

Medical Foods Products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

Medically Necessary Health Care Services that are ordered by a Health Provider, without which there would be significant risk of a serious deterioration and/or a significant impairment that, if not treated, could seriously affect one's ability to function within his or her normal environment. Although some Health Care Services are medically acceptable, they may not be medically necessary. Health Care Services need to be (1) medically appropriate and necessary to meet the basic health needs of the Member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; (4)

consistent with the diagnosis of the conditions; and (5) of demonstrated medical value. Medically Necessary does not include care that is provided primarily for the convenience of the Member or a Health Provider, or care that is rendered more frequently than that accepted as medically appropriate by the medical profession.

Medicare Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Member A Member means any Subscriber or Dependent.

Mental Illness Those Conditions classified as mental disorders in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, except mental retardation

Network Benefits Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network provider in the provider's office or at a Network or Non-Network facility.

Network/Network Provider When used to describe a provider of Health Care Services, this means a provider that has a participation agreement in effect with Us or with Our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of Our products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement, and a Non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

Neuropsychological Testing Neuropsychological Testing is a quantitative, comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders.

Non-Network Benefits Benefits for Covered Health Services that are provided by a Non-Network Physician or other Non-Network provider.

Observation Care Care in the Hospital to monitor evaluate or stabilize a patient in order to determine the need for further treatment or an inpatient admission. Such Care is not considered Inpatient Care, even though the patient may be confined to a Hospital bed.

Occupational Therapy Treatment of a physically or mentally disabled person through constructive activities designed to restore the ability to accomplish satisfactorily the ordinary activities of daily living. Activities of daily living include feeding, dressing, bathing and other types of self-care.

Out-of-Pocket Maximum If applicable, the maximum amount of Coinsurance You pay every CalendarYear. If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that Calendar Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that Calendar Year. See Section 6 (Your Cost for Covered Services).

Physical Therapy Treatment by physical means including hydrotherapy, heat, physical agents, and biomechanical and neurophysiological principles and devices that relieve pain or restore maximum bodily function. Physical Therapy does not include Cardiac Rehabilitation, Pulmonary Rehabilitation or Manipulation/Adjustment.

Physician Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that We describe a provider as a Physician does not mean that Benefits for

services from that provider are available to You under the Policy.

Policy This document including all riders, Amendments and Schedule of Coverage.

Policy Charge The sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy Includes all of the following:

- Prenatal care;
- Postnatal care;
- Childbirth.

Premium The periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Prior Authorization Precertification review by the Plan, before services and treatment are rendered, to determine if the service meets the criteria as a Covered Health Service.

Preventive Health Screening(s) Routine tests performed on a healthy individual who has no signs or symptoms of disease, or history of the disease being screened. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient or a patient previously diagnosed with the disease being screened are classified as diagnostic tests. Diagnostic tests will incur Deductibles and/or Copayments/Coinsurances consistent with the services received.

Private Duty Nursing Private Duty Nursing is defined as one-on-one care provided on an individual basis either in an institution or in a patient's home. Private duty skilled nursing care can be considered custodial after Non-professional personnel repetitively performs the care, making continuous attention by a health professional no longer necessary, and is therefore not a covered benefit.

Pulmonary Rehabilitation A comprehensive program to manage patients with substantial chronic lung disease. Includes diagnostic testing, monitored dynamic exercise and education under the direct supervision of a qualified Physician.

Rider Any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-Private Room A room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Health Service, the difference in cost between a Semi-Private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.

Sickness Physical illness, disease or Pregnancy. The term Sickness as used in this Policy does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal Care, Custodial Care, ambulatory Care, part-time Care, or Care for Mental Illness and Substance Abuse, pulmonary tuberculosis or venereal disease.

Speech Therapy Treatment for loss or impairment of speech or hearing, including communicative disorders resulting from genetic defects, birth defects, injury, illness, disease, developmental disabilities or delays or other causes, whether of organic or nonorganic etiology and whether or not the person suffering from that loss or impairment had the capacity for speech, language or hearing before the loss or impairment occurred.

Subscriber An Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued.

The Plan The Plan refers to Mercy Health Plans.

Unproven Services Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a Individual of patients who receive standard therapy.
- The comparison Individual must be nearly identical to the study treatment Individual.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Urgent Care Center A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of Your health, within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Us/We/Our Us/We/Our refers to Mercy Health Plans.

Usual and Customary Rate (UCR) Charges for Covered Health Services which do not exceed the fees and prices generally approved for cases of comparable nature and severity at the time and place when such Covered Services are rendered or received. In determining the Usual and Customary Rate (UCR), the following guidelines shall be taken into consideration:

a) The rate allowed by Medicare for that particular service or supply;
b) The prevailing rate of fees charged for identical or similar services in the same geographical area by health professionals of similar training and experience;
c) Unusual circumstances or complications that require additional time, skill and experience in connection with the provided service or supply;
d) The actual charge by the Provider (if less than Our UCR charge);
e) The frequency of the determination of the usual and customary fee;
f) A general description of the methodology used to determine usual and customary fees;
g) The percentile that determines the maximum benefit the Plan will pay for any Accidental Injury dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then making the benefit by selecting a percentile of those fees.

Utilization Review A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of Health Care Services, procedures or settings. Utilization Review may include Ambulatory Review, Prospective Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning or Retrospective Review, but will not include elective requests for clarification of Coverage.

You/Your You/Your refers to the Subscriber and each Enrolled Dependent.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MHP, Inc. by and on behalf of its wholly-owned subsidiaries, including Mercy Health Plans of Missouri, Inc., Mercy Health Plans, and Premier Benefits, Inc. (Collectively referred to as "the Plan"), respects the privacy of its Members and former Members and protects the security and confidentiality of their nonpublic personal information. We have instituted internal policies to: insure the security and confidentiality of Your personal and financial healthcare information; protect against any anticipated threats of hazards to the security or integrity of such records; and protect against unauthorized access to or use of information which could result in substantial harm or inconvenience to You. We are required by law to provide You with this Notice of Our legal duties and privacy practices. This Notice explains Your rights, Our legal duties, and Our privacy practices. To fulfill Our responsibilities to You, the Plan may use and disclose Your protected health information for treatment, payment, and healthcare operations, or when We are otherwise required or permitted to do so by law. Below is further detail explaining these situations.

TREATMENT
We may use and disclose protected health information with Your healthcare providers (physicians, pharmacies, hospitals and others) to assist in the diagnosis and treatment of Your injury or illness. For example, We may disclose Your protected health information to suggest treatment alternatives.

PAYMENT
We may use and disclose protected health information to pay for Your covered health expenses. For example, We may use protected health information to process claims. We may also ask a healthcare provider for details about Your treatment so that We may pay the claim for Your care.

HEALTHCARE OPERATIONS
We may use and disclose protected health information for Our healthcare operations. For example, We may use or disclose protected health information to perform quality assessment activities or provide You with case management services.

BUSINESS ASSOCIATES
We may, at times, need to use the services of other companies in lieu of Our own staff, such as outsourcing data entry services, or, as part of Our routine business, We may require that outside entities, such as auditors perform operations that require access to Our healthcare information. In order for Us to share confidential information with these organizations, We must enter into agreements that require them to comply with the privacy regulations of the Plan.

YOU OR YOUR PERSONAL REPRESENTATIVE
We must disclose Your health information to You as described in the Patient Rights Section below. If You have a legally-assigned personal representative or are an un-emancipated minor, We will release the information to Your personal representative or parent(s) as required by law.

FAMILY/FRIENDS
We may disclose Your health information to a family member or friend to the extent necessary to help with Your healthcare or with payment for Your healthcare, if You agree that We may do so. If You wish to designate a person(s) to whom We may discuss Your healthcare, You may submit a request to the address listed below. If You are physically or mentally unable to participate in decisions regarding Your healthcare, We may need to communicate with a family member; however, only to the extent necessary to insure that You receive appropriate healthcare treatment.

PERMITTED OR REQUIRED BY LAW
We must disclose protected health information about You when required to do so by law. Information about You may be used or disclosed to regulatory agencies, such as Medicare and Medicaid; for administrative or judicial hearings; public health authorities; or law enforcement officials, such as to comply with a court order or subpoena.

MEMBER AUTHORIZATION
Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding protected health information that the Plan maintains about You. If You wish to exercise any of these rights, You may submit Your request in writing.

- Right to Access Your Protected Health Information. You have the right to inspect and/or obtain a copy of individual protected health information that We maintain about You. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance.

- Right to Amend Your Protected Health Information. You have the right to request an amendment of individual protected health information that We maintain about You. All requests must be in writing and must include the reason for the change.

- Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of disclosures of individual protected health information made by the Plan on or after the compliance date of April 14, 2003. All requests must be in writing and must state the period of time for which You want the accounting. We may charge for providing the accounting, but We will tell You the cost in advance.

- Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that the Plan restrict the use and disclosure of Your protected health information for treatment, payment, or healthcare operations. The Plan is not required to agree to the requested restriction; however, if the Plan does agree to the restriction, it must comply with Your request, unless the information is needed for an emergency.

- Right to Receive Confidential Communications. You have the right to request to receive communication of protected health information from the Plan through an alternative procedure (other than the standard means of communicating protected health information). All requests must be in writing and are subject to technical reasonability for the Plan.

- Right to a Paper Copy of This Notice. You have the right at any time to receive a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.

CHANGES
The Plan reserves the right to change the terms of this Notice at any time, effective for protected health information that We already have about You as well as any information that We receive in the future. We are required by law to comply with whatever Notice is currently in effect. We will communicate changes to Our Notice through subscriber newsletters, direct mail and/or Our Internet website (www.mercyhealthplans.com).

COMPLAINTS
If You believe Your privacy rights have been violated, You have the right to file a complaint with the Plan and/or with the Federal Government. Complaints to the Plan may be directed to the appropriate Customer Contact Center listed at the end of this Notice or by calling the Customer Contact Center number listed on the back of Your ID card. You may also file a complaint anonymously by calling the Plan's Fraud and Abuse Hotline at 1-877-349-5997. Complaints to the government may be sent to: Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.

CONTACT THE PLAN
If You want more information about this Notice, how to exercise Your rights, or how to file a complaint, please direct Your correspondence to the appropriate Customer Contact Center listed at the end of this Notice or call the Customer Contact Center phone number listed on the back of Your ID card. You can also contact Us through Our Internet website: www.mercyhealthplans.com

Mercy Health Plans
ATTN: Customer Contact Center
14528 S Outer 40, Suite 300,
Chesterfield, MO 63017-5743

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for Your policy, contract or any portion of it that is not guaranteed by the insurer, or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverage, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act, or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);

- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a non-affiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance Benefits, $300,000 in present value of annuity Benefits, or $300,000 in life insurance death Benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity Benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those Benefits could be provided out of the assets of the impaired or insolvent insurer.

SCHEDULE OF COVERAGE AND BENEFITS
for
[NAME]
Effective Date of Coverage [MM/DD/YYYY]

With Mercy Health Plans' conversion Policy, You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider. You must show Your identification card (ID card) every time You request health care services from a Provider.

Please refer to Your Policy for a detailed explanation of covered and non-covered services In some cases, You must notify Us before receiving services.

PAYMENT INFORMATION	AMOUNT	
	NETWORK	NON-NETWORK
MEDICAL SERVICES **Annual Deductible**	[$500 - $2,500] per Covered Person per Calendar Year, not to exceed $3,000 for all Covered Persons in a family.	[$1,000 - $5,000] per Covered Person per Calendar Year, not to exceed $6,000 for all Covered Persons in a family.
Out-of-Pocket Maximum *Coinsurance is the amount You pay after You meet Your Deductible. All Coinsurances apply towards Your Out-of-Pocket Maximum, except those related to Covered Health Service contained in an optional Rider.* **Out-of-Pocket Maximum does not include the Annual Deductible.**	**Network and Non-Network** [$1,000 after Deductible per individual per Calendar Year, not to exceed $3,000 for all Covered Persons in a family.] [No Out-of-Pocket Maximum]	**Non-Network** No Out-of-Pocket Maximum
Maximum Policy Benefit	**Network and Non-Network Combined** $250,000 per Covered Person	

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
1. Ambulance Services - Emergency Only • Ground Transportation • Air Transportation ✸	*Ground Transportation:* 20% Coinsurance after Deductible *Air Transportation:* 45% Coinsurance after Deductible per transport	*Ground Transportation:* 45% Coinsurance after Deductible *Air Transportation:* 45% Coinsurance after Deductible
2. Dental Anesthesia and Facility Charges ✸ Coverage is limited to: • A Covered Person who is a child under the age of seven (7) who is determined by two (2) dentists to require necessary dental treatment; or • A Covered Person who is severely disabled; or • A Covered Person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.	20% Coinsurance after Deductible	45% Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
3. Diabetes Services ✸ Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes.	20% Coinsurance after Deductible Copayment/Coinsurance consistent with type of service required.	45% Coinsurance after Deductible
4. Emergency Room Services Physician charges may be applicable, if billed separately. See *Professional Fees for Surgical and Medical Services* below. Copayment/Coinsurance charge will be waived when hospital inpatient or observation admission for the same condition occurs within twenty-four (24) hours.	[$0 - $250 Copayment per visit] [20% Coinsurance after Deductible]	[$0 - $250 Copayment per visit] [45% Coinsurance after Deductible]
5. Hearing Screenings for Newborns	20% Coinsurance after Deductible	45% Coinsurance after Deductible
6. Immunization - Routine Only (Received in Physician's Office)	20% Coinsurance after Deductible for adults over 18 yrs. No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.	45% Coinsurance after Deductible. No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.
7. Inpatient Hospital Services ✸ Semi-Private Room covered.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
8. In-Vitro Fertilization ✸ Covered Health Services for In-Vitro Fertilization (IVF) include the following: • IVF associated labs; • Medication; • Imaging and procedures including female and male pre-testing; • The IVF process, and; • Cryopreservation. Any combination of Network and Non-Network Benefits for in-vitro fertilization is limited to a lifetime maximum $15,000**.**	20% Coinsurance after Deductible Member is responsible for the remaining 100% of the charges for infertility services over $15,000.	45% Coinsurance after Deductible Member is responsible for the remaining 100% of the charges for infertility services over $15,000.]
9. Maternity Services ✸	*Physician Office*: 20% Coinsurance after Deductible No Copayment applies to Physician office visits for prenatal care after the first visit. *Hospital Outpatient- Observation*: 20% Coinsurance after Deductible per visit *Hospital Inpatient Services*: 20% Coinsurance after Deductible *Outpatient Laboratory services:* 20% Coinsurance after Deductible *Outpatient X-ray/Imaging:* 20% Coinsurance after Deductible	*Physician Office:* 45% Coinsurance after Deductible *Hospital Outpatient- Observation*: 45% Coinsurance after Deductible *Hospital Inpatient Services*: 45% Coinsurance after Deductible *Outpatient Laboratory services:* 45% Coinsurance after Deductible *Outpatient X-ray/Imaging:* 45% Coinsurance after Deductible
10. Newborn Child Coverage ✸	20% Coinsurance after Deductible	45% Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
11. Observation Care ✸ If an Observation admission results in a conversion to an Inpatient Admission, the Observation Copayment will be waived. The alternate Copayment/Coinsurance will apply.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
12. Osteoporosis Services/Bone Mineral Density (BMD) Testing ✸ Diagnosis, treatment, and appropriate management of osteoporosis are covered for persons with a condition or medical history for which bone mass measurement is medically indicated. When these services are performed in a Physician's office, Physician's charges may apply. See *Physician's Office Services* below. A list of osteoporosis services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling our Customer Contact Center at the number listed on Your ID card.	*Laboratory Services*: 20% Coinsurance after Deductible *X-ray/Imaging:* 20% Coinsurance after Deductible *Other Diagnostic/Therapeutic Services*: 20% Coinsurance after Deductible	*Laboratory Services*: 45% Coinsurance after Deductible *X-ray/Imaging:* 45% Coinsurance after Deductible *Other Diagnostic/Therapeutic Services*: 45% Coinsurance after Deductible
13. Outpatient Diagnostic Services ✸ Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility include: • Laboratory services • X-Ray/Imaging • Other diagnostic & therapeutic services The following services are subject to the outpatient diagnostic charges regardless of the place of service: • MRA • MRI • CT Scan • PET Scan • Nuclear Cardiology Imaging studies. A list of diagnostic/imaging services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling our Customer Contact Center at the number listed on Your ID card.	Laboratory Services : 20% Coinsurance after Deductible X-Ray/Imaging 20% Coinsurance after Deductible Other Diagnostic & therapeutic services: 20% Coinsurance after Deductible	Laboratory Services : 45% Coinsurance after Deductible X-Ray/Imaging : 45% Coinsurance after Deductible Other Diagnostic & therapeutic services: 45% Coinsurance after Deductible
14. Outpatient Surgery/Hospital Procedures ✸ Coverage includes surgical services and hospital procedures received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and*	Outpatient Surgery/Hospital Procedures: 20% Coinsurance after Deductible per outpatient surgery or procedure	45% Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
Medical Services below and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment. • Surgical Implants Implants for cosmetic or psychological reasons are excluded, see Section 12, M. in Your Policy.	Surgical Implants*:* [Copayment consistent with type of service received]. [20%] [45%] Coinsurance after Deductible]]	Surgical Implants*:* [Copayment consistent with type of service received]. [45% Coinsurance after Deductible]
15. Physician's Office Services	20% Coinsurance after Deductible	45% Coinsurance after Deductible
16. PKU/Medical Foods and Low Protein Modified Food Products for Metabolic Disorders Please refer to Your Policy Section 11 (Covered Benefits) for limitations.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
17. Preventive Health & Wellness Care Services may be performed in a Physician's office or an outpatient facility and may incur both a professional fee and/or outpatient facility charges. Coinsurance will be consistent with type of service received. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient diagnostic services are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Physician's charges may apply. See *Physician's Office Services* above.	*Cholesterol Tests:* [0% -45%] Coinsurance after Deductible *Colon Screening:* [0% - 45%] Coinsurance after Deductible *Well-Woman:* [0% - 45%] Coinsurance after Deductible *Prostate Exam:* [0% - 45%] Coinsurance after Deductible *PSA test:* [0% - 45%] Coinsurance after Deductible *Diabetes A1C Test:* [0% - 45%] Coinsurance after Deductible *Osteoporosis Services:* [0% - 45%] Coinsurance after Deductible	[Covered In-Network only]
18. Professional Fees for Surgical and Medical Services	20% Coinsurance after Deductible	45% Coinsurance after Deductible
19. Reconstructive Procedures ✸ Please refer to Your Policy Section 11 (Covered Benefits) for limitations.	20% Coinsurance after Deductible	45% Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
20. Rehabilitation Services Outpatient Rehabilitation Therapy Any combination of Network and Non-Network Benefits is limited as follows: ▪ 60 Combined visits per Calendar Year for Physical, Occupational and Speech Therapy ▪ 36 Visits of Pulmonary Rehabilitation Therapy within a 12-week period per [Calendar] [Plan] Year. ▪ 36 Visits of Cardiac Rehabilitation Therapy within a 12-week period per [Calendar] [Plan] Year. Inpatient Rehabilitation Services ✸ Any combination of Network and Non-Network Benefits is limited up to a maximum of [60 – 120] days per [Calendar] [Plan] Year. Rehabilitation Therapy services that are considered maintenance, developmental or educational in nature are not covered Benefits.	Outpatient Rehabilitation Therapy Physical Therapy/Occupational Therapy/Speech Therapy: 20% Coinsurance after Deductible Pulmonary Rehabilitation: 20% Coinsurance after Deductible Cardiac Rehabilitation: 20% Coinsurance after Deductible Inpatient Rehabilitation Services [0% - 45%] Coinsurance after Deductible] [$0 - $5,000] per Inpatient Stay] [$0 - $1,000] Copayment per day] [$0 - $1,000] Copayment per day to a maximum of [$0 - $5,000] Copayment per Inpatient Stay]	Outpatient Rehabilitation Therapy 45% Coinsurance after Deductible Inpatient Rehabilitation Services [0% - 45%] Coinsurance after Deductible
21. Skilled Nursing Facility (SNF) ✸ Any combination of Network and Non-Network Benefits is limited to [60-120] days per Calendar Year.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
22. Urgent Care Center Services Covered Health Services received at an Urgent Care Center that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. If radiology and other diagnostic services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply.	[$0 - $250 Copayment] per visit] [No Copayment] [20% Coinsurance after Deductible]	[$0 - $250 Copayment] per visit] [0% - 45%] Coinsurance after Deductible

OPTIONAL RIDERS		
	NETWORK	NON-NETWORK
[Temporomandibular Joint Disorder (TMJ)] [When these services are performed in a Physician's office, Benefits are described under *Physician Office Services* above.] [Coinsurance consistent with applicable inpatient hospital, outpatient, hospital or other services required.]	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

CRANIOMANDIBULAR AND
TEMPOROMANDIBULAR JOINT DISORDER (TMJ) RIDER

1. This Rider amends the Policy and all the relevant Schedules and Riders attached thereto (collectively the "Policy"), and unless otherwise expressly stated in this Rider is subject to all provisions, exclusions and limitations set forth in the Policy.

2. Except as modified or superceded by the coverage provided under this Rider, all other terms, conditions (including pre-existing), and exclusions in the Policy remain unchanged and in full force and effect. For purposes of this Rider, capitalized terms shall have the meaning assigned to them in the Policy.

3. Covered Services:

   Coverage for the Medically Necessary treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including the diagnosis and treatment of temporomandibular joint disorders (TMJ) and craniomandibular disorder. Treatment shall include surgical and non-surgical procedures for Medically Necessary diagnosis and treatment, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

4. Copayments:

   The Covered Person shall be required to pay the same Copayment or Deductible and Coinsurance with respect to the health services described in this Rider as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an Illness or Injury, including (but not limited to) the Copayment or Deductible and Coinsurance generally applicable to inpatient hospital and outpatient hospital services and office visits. The Coinsurance described in this Rider shall not be counted against the applicable Out-Of-Pocket maximum as set forth in the Schedule of Coverage and Benefits. Deductibles do not apply to your Out-Of-Pocket Maximum as set forth in the policy.

5. Exclusions:

   Under no circumstances will coverage be provided for:

   a) Services for care of teeth such as routine Preventive Care Services that would normally be covered under a dental plan, and including (but not limited to) periodic oral exams, periapical or bitewing x-rays, and cleanings/prophylaxis.
   b) Services beyond the scope of the Physician's license to practice oral surgery.
   c) Services, including consultations that have not received Prior- Authorization.

Prior Authorization

Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.

Charles S. Gilham, Vice-President
Mercy Health Plans

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 09/17/2008
Comments:
Attachment:
AR CONV Certification.PDF

Bypassed -Name: Application **Review Status:** Approved-Closed 09/17/2008
Bypass Reason: N/A
Comments:

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 09/17/2008
Bypass Reason: N/A per Rule & Reg #18 - Section 3. Applicability and Scope
Comments:

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 09/17/2008
Comments:
Please see attached cover letter.
Attachment:
AR CONV Cover Letter_07.28.08.pdf

Satisfied -Name: Redlined documents **Review Status:** Approved-Closed 09/17/2008
Comments:
See attached redlined documents
Attachments:
AR Conversion COC (08)_Redlined.pdf
PHI AR CONV SCH (08)_ Redlined.pdf

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Satisfied -Name: Redlined Document

Review Status:
Approved-Closed 09/17/2008

Comments:

Attachment:
AR Conversion COC_Redlined_8,9.pdf

CERTIFICATION

I, Charles S. Gilham, am a duly authorized officer of Mercy Health Plans and do hereby certify that, per Rule and Regulation 19 and 42, Section 5 (b), there will be no unfair discrimination with respect to the medical/lifestyle application questions and underwriting standards.

7-21-08

Charles S. Gilham, Vice President General Counsel — Date

Mercy Health Plans
14528 S. Outer 40, Suite 300
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 214-8294

STATE OF Missouri
COUNTY OF St. Louis

Subscribed and sworn to before me this 21 day of July, 2008.

Signature of Notary Public

CAROL NACHTWEIH

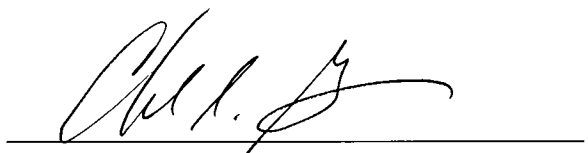
(NOTARY SEAL)

Printed Name of Notary Public

In and for the State of Missouri
My Commission expires: 3-15-09

CERTIFICATION

I, Charles S. Gilham, a duly authorized officer of Mercy Health Plans with the title of Secretary, do hereby certify that all benefits payable will comply with the Arkansas Bulletin 9-85 and that the difference between network and non-network deductibles, copays and coinsurances will not exceed 25%.



7-21-08

Charles S. Gilham, Vice President General Counsel
Mercy Health Plans
14528 S. Outer 40, Suite 300
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 214-8294

Date

July 28, 2008

Ms. Rosalind Minor
Senior Certified Rate and Form Analyst
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE:

PHI AR CONV (08)	**Individual Conversion Policy**
PHI AR CONV SCH (08)	**Schedule of Coverage & Benefits**
PHI AR CONV/TMJ (08)	**TMJ Rider**

Dear Ms. Minor:

I have enclosed for your review and approval the documents listed above, and the following:

- An Actuarial Memorandum and Certification of Rates for this Conversion product
- The required Policy Form Compliance Certification
- Certification according to Arkansas Bulletin 9-85
- Filing fee of $50

The documents in this filing will be used for Mercy Health Plans' (MHP) Individual Conversion PPO product. They are all new documents. This product will be offered to employees, members or covered dependents whose insurance under a group policy has been terminated.

Our Arkansas sales office currently has a group that is interested in this Conversion Plan. We would appreciate any consideration for an expedited review.

Should you have any questions, please contact me by phone at (314) 214-8263 or by email at smcginni@mhp.mercy.net.

Sincerely,

Sue McGinnis

Sue McGinnis
Contract Specialist

Your Individual Conversion Policy

Issued by: Mercy Health Plans

This Individual Conversion Policy is guaranteed renewable

NOTICE:

The Benefits in this Policy do not necessarily equal or match those Benefits provided in Your previous group Policy

This Health Plan is underwritten by Mercy Health Plans. The Benefits and main points of coverage under the Plan are set forth in this Individual Conversion Policy and Schedule of Coverage and Benefits and any attached Riders. The Benefits are effective only while You are covered by this conversion Policy. The Benefits in this Policy do not necessarily equal or match those benefits provided in your previous group Policy.

This Policy describes the Benefits for health care services provided by Mercy Health Plans and the extent to which Benefit Payment may be limited. The Policy may be terminated by Mercy Health Plans or by You as described in this Policy.

You may return this Policy within ten (10) days of its receipt for full refund of any Premiums paid if, after examining it, You are not satisfied for any reason. Written notification is required to return this Policy. If services are utilized during this (10) day period, this policy is assumed to be accepted. Any coverage returned for a refund of premium will be null and void from its inception.

Mercy Health Plans
14528 S Outer 40, Suite 300
Chesterfield, Missouri 63017
314-214-8100
800-830-1918
www.mercyhealthplans.com

Table of Contents

Individual Health Conversion Policy

The Individual Health Conversion Policy is a legal document between **Mercy Health Plans** (**"The Plan", "We", "Us", "Our"**) and **the Enrolling Individual** (**"You", "Your"**) to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrollee's application and payment of the required Policy premium within thirty (30) days after termination from Your group health policy.

The Policy includes:

- The Enrollee's application;
- Any Amendments and Riders;
- The Schedule of Coverage and Benefits and any inserts to the Conversion Policy.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens We will send You the revised Policy, Rider or Amendment pages.

No one has the authority to make any changes to the Policy unless those changes are in writing and signed by an officer of Mercy Health Plans. No change shall be valid until approved and made part of the Policy. Only the Plan has the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without Your approval.

Information You Should Have

This Policy describes Benefits in effect as of Effective Date of Policy Issuance.

On its Effective Date, this Policy replaces and overrules any Policy that We may have previously issued to You, or Your employer. This Policy will in turn be overruled by any Policy We issue to You in the future.

Coverage under the Policy will begin at 12:01 a.m. on the Effective Date and end at 12:00 midnight on the Termination Date. The Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to termination of the Policy.

This Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

We are delivering the Policy in the State of Arkansas. The laws of the State of Arkansas govern this Policy.

The validity of the Policy will not be contested after the Policy has been in force for three (3) years from the date of issue. No statement relating to insurability, made by any person covered under the Policy, will be used to contest the validity of the Policy after it has been in force for a period of three (3) years. In addition, the statement must be contained in a written instrument signed by the person making the statement. The assertion, at any time, of defenses based upon the person's ineligibility for coverage under the Policy, or upon other provisions in the Policy, will not be precluded.

Section 1: Introduction to Your Policy

We encourage You to read Your Policy and any attached Riders and/or Amendments carefully.

Information about Defined Terms

Because this Policy is part of a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in Section 13 (Definitions of Terms). You can refer to Section 13 as You read this document to have a clearer understanding of Your Policy of Coverage.

When We use the words **"The Plan"**, **"We", "Us", and "Our"** in this document, We are referring to **Mercy Health Plans.** When We use the words **"You" and "Your",** We are referring to people who are **Covered Persons** as the term is defined in Section 13 (Definitions of Terms).

This Policy and the other Policy documents describe Your Benefits as well as Your rights and responsibilities under the Policy.

We especially encourage You to review the Benefit limitations of this Policy by reading Section 11 (Covered Benefits) and Section 12 (Exclusions). You should also carefully read Section 10 (General Provisions) to better understand how this Policy and Your Benefits work. You should call Us if You have questions about the coverage available to You.

Many of the Sections of the Policy are related to other Sections of the document. You may not have all of the information You need by reading just one Section. We also encourage You to keep Your Policy and any attachments in a safe place for Your future reference.

Please be aware that Your Physician does not have a copy of Your Policy of Coverage, and is not responsible for knowing or communicating Your Benefits.

Required Premiums, Premium Changes and Grace Period

The Plan requires payment of ~~p~~Premiums by the 15th of each month for this Policy. You must pay the required premium within a 31-day grace period to keep this Policy in force. All premiums must be paid via any one of the following methods:

- ACH Direct Debit Program
- Credit Card payment
- A ~~C~~check for the entire annual Premium

Your Conversion Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

Upon the payment of a claim under this Policy, any Premium then due and unpaid or covered by any note or written order may be deducted from the claim payment. We may change the amount of Your Premiums on any monthly due date upon giving You sixty (60) days prior written notice.

We may change the terms and conditions of this Policy to conform to the laws of the State of Arkansas, to conform to Federal law or to conform to underwriting policies established by Mercy Health Plans, after submission to and approval by the Arkansas Insurance Department. For changes in terms and conditions, We must give written notice thirty (30) days before the change. This notice may be in the form of a new Policy, or a Rider or Amendment to this Policy.

Don't Hesitate to Contact Us

Throughout the document You will find statements that encourage You to contact Us for further information. Whenever You have a question or concern regarding Your Benefits, please call Us using the telephone number for Our Customer Contact Center listed on Your ID card.

Section 2: Eligibility

How to Enroll

If Eligible, the Enrolling Individual must complete an enrollment application and submit the properly completed form to Us, along with any required Premium within thirty (30) days after termination of Your group health policy. We will not provide Benefits for health services that You receive before Your Effective Date of coverage.

If You Are Hospitalized When Your Coverage Begins

If You are a patient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the effective date of this Policy, We will pay Benefits for Covered Health Services related to that Inpatient Stay as long as You receive Covered Health Services in accordance with the terms of the Policy.

If You are hospitalized when Your coverage begins, You should notify Us within forty-eight (48) hours of Your effective date, or as soon as is reasonably possible. Network Benefits are available only if You receive Covered Health Services from Network Providers.

Who is Eligible for Coverage?

To be eligible for this coverage, Your primary domicile must be within Arkansas.

A converted policy need not be made available if termination occurred for any of the following reasons:

1. You failed to make timely payment of any required contribution.
2. The Group Policy terminated or a group's participation terminated, and the insurance is replaced by similar coverage under another Group Policy within thirty-one (31) days of the date of termination.
3. An individual may convert to a conversion policy and remain covered by that policy until all preexisting conditions are covered or would be covered under another group policy or contract.

Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under your group Policy.

The converted policy shall cover the employee or Member and his/her Dependents who were covered by the Group Policy on the date of termination of insurance.

Who is Not Eligible to Enroll?

We are not required to issue a converted policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted policy covering any person if:

- Such person is or could be covered for similar benefits by another individual policy;
- Such person is or could be covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured, or similar benefits are provided for or available to such person, by reasons of state or Federal law; and
- The benefits under sources of the kind referred to above for such person, or benefits provided or available under sources of the kind referred to above for such person, together with the converted policy's benefits would result in over-insurance according to the insurer's standards for over-insurance.

Persons not eligible for coverage include –

a) Those whose coverage was previously terminated for the following causes:
   - Fraud or misrepresentation in the application;
   - Abuse of services or facilities;
   - Improper use of ID Card;
   - Misconduct detrimental to Plan operations and the delivery of services;
   - Failure to pay Premiums more than twice in the past 12 months, or to pay Premiums in a timely manner in accordance with the terms of the Policy.

Refer to Section 4 (When Coverage Ends) for a detailed description of these causes that lead to termination.

Section 3: When Coverage Begins

Initial Enrollment Period

The Initial Enrollment Period is the first time You enroll Yourself and/Your eligible Dependents, subject to acceptance by the Plan. Coverage begins on the Effective Date as determined by the Plan and when We approve Your completed application and receive ~~the~~any required Premium. Only a Subscriber or Dependent that was covered under the group Policy this conversion Policy replaces on the date of termination of such group Policy are Eligible to enroll in this Policy.

Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is Totally Disabled because of a mental or a physical disability will not end just because the child has reached a certain age. We will extend the coverage for the disabled child beyond the limiting age if both of the following are true:

- The disabled child is not able to be self-supporting because of a mental or physical disability; **and**
- The disabled child depends primarily on the Subscriber for support and maintenance due to the mental or physical disability.

Coverage will continue as long as the Enrolled Dependent is disabled and continues to satisfy both of these qualifying conditions, unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask You to furnish Us with proof of the disabled child's incapacity and dependency within a reasonable time after the date coverage would otherwise have ended because the child reached a certain age. Before We agree to this extension of coverage for the child, We may require that a Physician chosen by Us examine the child. We will pay for that examination.

We may continue to ask You for proof that the disabled child still meets these two conditions, but will not ask more than once per year. The proof We ask for might include medical examinations at Our expense.

If You do not provide proof acceptable to Us of the disabled child's incapacity and dependency, as described above, coverage for that child will end.

Section 4: When Coverage Ends

General Information about When Coverage Ends:

- We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.
- Your entitlement to Benefits automatically ends on the date that coverage ends, even if You are hospitalized or are otherwise receiving medical treatment on that date.
- When Your coverage ends, We will still pay claims for Covered Health Services that You received before Your coverage ended. However, once Your coverage ends, We do not provide Benefits for health services that You receive for medical conditions that occurred after Your coverage ended.
- An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Events Ending Your Coverage

Your coverage ends on the earliest of the dates specified in the following outline:

Event	Description
The Entire Individual Policy Ends	Your coverage ends on the date the Individual Policy ends. The Plan is responsible for notifying You that Your coverage has ended.
You Are No Longer Eligible for Coverage	Your coverage ends on the date You are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 2 (Eligibility) and Section 13 (Definitions of Terms) for more information. **When You turn age 65 or become eligible for Medicare, or ~~are covered~~have full coverage by a similar health insurance plan (group or individual) which provides benefits for all preexisting conditions, or are eligible for similar benefits provided by state or federal laws, You are no longer eligible for this conversion coverage.** If ~~y~~Your coverage ends due to Your death and ~~w~~We receive notification within one (1) year of Your death, ~~p~~Premiums paid for coverage beyond the date of Your death will be refunded to You or ~~y~~Your estate within thirty (30) days after We receive written proof of Your death.
We Receive Notice to End Coverage	Your coverage ends at the end of the month that We receive Your request in writing. We must receive Your termination notice **prior** to Your requested date of termination. Your Conversion Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period.
Fraud, Misrepresentation or False Information	Your coverage ends on the date We identify, in a notice, that Your coverage is terminated because of fraud or misrepresentation. We will provide written notice to the Subscriber that coverage has ended. During the first three (3) years the Policy is in effect, if You provided Us with false information or misrepresentation of material facts regarding Your application or coverage, We have the right to demand that You pay back all Benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under the Policy. After the first three (3) years, We can only demand that You pay back these Benefits if the written application contained a fraudulent misstatement.

Event	Description
Abuse of Services or Facilities	In the event of abuse by a Covered Person in the use of services or facilities, that person's coverage may be restricted or canceled by the Plan upon at least thirty-one (31) days' prior written notice to the ~~Individual and the~~ Member.
~~Death of Subscriber~~Death of Subscriber	~~Coverage ends for the Subscriber and his/her Dependents as of the date of the Subscriber's death.~~Coverage ends for the Subscriber and his/her Dependents as of the date of the Subscriber's death.
Improper Use of ID Card	Your coverage ends when You permit an unauthorized person to use Your ID card, or You used another person's card. When Your coverage is terminated because of improper use of Your ID card, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice.
Misconduct	In the event Your misconduct is detrimental to the safe Plan operations and the delivery of services, Your coverage may be cancelled immediately.
Moving Out of State	Coverage will end within sixty (60) days after We receive notice of Your move out of Arkansas.
Non-Payment of Premiums	This Policy will automatically end on the last day of the period for which Premiums have been paid. If Premiums are not paid within the grace period, thirty-one (31) days from the premium due date, there will be no reinstatement.

Section 5: How You Get Care

Identification cards

We will send You an identification (ID) card when You enroll. You should carry Your ID card with You at all times. You must show it whenever You receive services from a Network Provider. If You do not show Your ID card, Network Providers have no way of knowing that You are enrolled under Our Conversion Policy. As a result, they may bill You for the entire cost of the services You receive.

If You do not receive Your ID card within thirty (30) days after the Effective Date of Your enrollment, or if You need replacement cards, call Us at 866-647-5568. You must show Your ID card every time You request Health Care Services from a Network Provider.

Where You get covered care

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Individual Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 4 (When Coverage Ends) occurs.
- The person who received Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

You will only pay Copayments, Deductibles, and/or Coinsurances when receiving care from a Network Provider for a Covered Health Service. If You use Non-Network Providers, it will cost You more.

Network Providers

Network Providers are ~~p~~Physicians and other health care professionals that We contract with to provide Covered Services to Our Members. Network Providers are independent practitioners. They are not Our employees. It is Your responsibility to select Your provider. We credential Network Providers according to national standards. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

A directory of Network Providers is available on our website at www.mercyhealthplans.com We update the provider directory periodically. However, before obtaining services You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Our Customer Contact Center at 866-647-5568.

It is possible that You might not be able to obtain services from a particular Network Provider. The Network of providers is subject to change. You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of Our products. Refer to Your provider directory or contact Us for assistance.

Extended Provider Network

Mercy Health Plans has an extended provider network **outside** of Our contracted network called Private Healthcare Systems Preferred Provider Organization (PHCS PPO). This extended Provider Network is available to You as Network Benefits only when you are **outside** of Our contracted network. To find a PHCS PPO provider, call Our Customer Contact Center or visit www.phcs.com and select the PPO Network.

PHCS PPO Network is not available when you receive services **within** Mercy Health Plans' contracted network.

Network Benefits

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services that are described as Network Benefits in Section 11 (Covered Benefits) and are any of the following:

- Provided by a Network Physician or other Network Provider.
- Emergency Room Services.

Designated Facilities and Other Providers

If You have a medical condition that We believe needs special services, We may direct You to a Designated Facility or other Network Provider chosen by Us. Network Benefits will only be paid if Your Covered Health Services for that condition are provided by, or arranged by the Network Designated Facility, or other Network Provider chosen by Us. Non-Network Benefits will apply to any Non-Network facility or provider.

Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by Non-Network Physicians or Non-Network Providers.

What You must do to get covered care

You or Your physician must notify Us and obtain Prior Authorization before getting certain Covered Health Services from either Network or Non-Network Providers. However, **You are responsible for ensuring that Your provider obtains any required Prior-Authorization before You receive Covered Health Services.** A current list of those services and supplies requiring Prior Authorization is available by calling Our Customer ~~e~~Contact Center at the telephone number listed on Your ID card, or by visiting www.mercyhealthplans.com. Verify with your Physician, or Our Contact Center, the authorized date range, and the number and type of services.

We urge You to confirm with Us that the services You plan to receive are Covered Health Services. Prior Authorization does not mean Benefits are payable in all cases. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before You receive treatment, You can check to see if the service is subject to limitations or exclusions including, but not limited to:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered ~~e~~Cosmetic include: breast reconstruction; vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty;
- The Experimental, Investigational or Unproven Services exclusion;
- Any other contract limitation or exclusion.

FAILURE TO PREAUTHORIZE CERTAIN BENEFITS MAY RESULT IN A REDUCTION OF ELIGIBLE EXPENSES.

Care Management

When You notify Us as described above, We will work together to implement the ~~C~~care ~~M~~management process and to provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Room Services

We provide Benefits for Emergency Room Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Services, even if a Non-Network Provider provides the services. Emergency Services and any follow-up care rendered by a Non-Network Provider must be:

1. Of such immediate nature that Your health would be jeopardized if taken to a Network Hospital where the services of a Participating Physician would be available, or
2. Provided under circumstances under which You are unable, due to Your condition, to

request treatment at a location where the services of a Participating Physician would be available.

- If You are admitted as an inpatient to a Network or Non-Network Hospital after You receive Emergency Room Services, We must be notified within two (2) working days or on the same day of admission, or as soon as reasonably possible to receive authorization for continued services. Continuation of care as for any Inpatient Stay requires Prior Authorization and approval by the Plan.
- If You are admitted as an inpatient to a Non-Network Hospital after you receive Emergency Room Services, We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date We decide a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
- If You are admitted as an inpatient to a Network or Non-Network Hospital within twenty-four (24) hours of receiving treatment for the same condition as an Emergency Service, You will not have to pay the Copayment for Emergency Room Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

Urgent Care Services

Covered Health Services that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. Urgent Care is not the same as Emergency Care.

Section 6: Your Cost for Covered Services

This is what You will pay for covered care:

Copayments

A Copayment is a fixed amount of money You pay to the provider, facility, pharmacy, etc., when You receive *certain* services. **Copayments do not count towards Your Out-of-Pocket Maximum or Your Deductible.** Copayment amounts are listed on the Schedule of Coverage and Benefits next to the description for each Covered Health Service.

Coinsurance

Coinsurance is the percentage of Our Eligible Expenses that You must pay for Your care. Coinsurance doesn't begin until after You meet Your Deductible. **Only Coinsurances count toward Your Out-of-Pocket Maximum.**

Deductible

A Deductible is a fixed expense You must incur within a ~~[~~Calendar Year~~] [Plan Year]~~ for certain Covered Services and supplies before We start paying Benefits for them. For a complete definition of Annual Deductible, see Section 13 (Definitions of Terms).

NOTE: The Network Deductible does not apply to the Non-Network Deductible; also, the Non-Network Deductible does not apply to the Network Deductible.

Deductibles do not apply to Your Out-of-Pocket Maximum.

For Your Annual Deductible see Your Schedule of Coverage and Benefits.

Eligible Expenses

Eligible Expenses are the amount We determine that We will pay for Benefits minus any Copayment, Coinsurance or Deductible. We will pay a contracted rate for Network Providers. For Non-Network Providers, however, We will pay the Usual and Customary Rate (UCR) as determined by Us. For a complete definition of Eligible Expenses and UCR that describes how We determine payment, see Section 13 (Definitions of Terms).

Charges in Excess of the UCR

Charges by a provider in excess of UCR will not be covered under this Policy and will not be counted toward Your Out-Of-Pocket Maximum limit or Deductible.

For Network Benefits, You are not responsible for any difference between the Eligible Expenses and the amount the provider bills, but You are responsible for all Copayments, Coinsurances or Deductibles.

For Non-Network Benefits, You are responsible to pay, directly to the Non-Network ~~p~~Provider, any difference between the amount the provider bills You and the UCR amount We will pay for Eligible Expenses. Please see Section 12 (Exclusions).

Out-of-Pocket Maximum

The maximum You pay out of Your pocket in a ~~[~~Calendar~~] [Plan]~~ Year for Coinsurances. For a complete definition of Out-of-Pocket Maximum, see Section 13 (Definitions of Terms).

If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that ~~[~~Calendar~~] [Plan]~~ Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that ~~[~~Calendar~~] [Plan]~~ Year.

The Out-of-Pocket Maximum does not include any of the following:

- Any charges for Non-Covered Health Services;
- Copayments~~/Coinsurance~~ for Covered Health Services available by an optional Rider;
- The amount of any reduced Benefits if You don't obtain Prior Authorization as described in Section 11 (Covered Benefits);
- Charges that exceed Eligible Expenses;
- Any Copayments for Covered Health Services in Section 11 (Covered Benefits);
- The Annual Deductible.

For Your Annual Out-of-Pocket Maximum see Your Schedule of Coverage and Benefits.

Maximum Policy Benefit

The maximum amount We will pay for Benefits during the entire period of time You are enrolled under the Policy. For a complete definition of Maximum Policy Benefit, see Section 13 (Definitions of Terms).

For Your Maximum Policy Benefit see Your Schedule of Coverage and Benefits.

Section 7: How to File a Claim

Network Provider

We pay Network Providers directly for Your Covered Health Services~~.~~, so Network Providers file claims on Your behalf to us. If a Network Provider bills You for any Covered Health Service, contact Us. However, You ~~will be~~are responsible for meeting any Annual Deductible and paying Copayments or Coinsurance to a Network Provider at the time of service or when You receive a bill from the Provider~~at the time of service~~.

Non-Network Provider

When You receive Covered Health Services from a Non-Network Provider, You may be responsible for paying for all expenses up front and then requesting reimbursement from Us.

How to File a Claim

While You do not need to fill out a specific claim form, You must file the claim in a format that contains all of the information We require, as described below.

If a Subscriber provides written authorization to a Non-Network Provider for payment of medical ~~b~~Benefits for any Eligible Expenses, reimbursement may be paid directly to that Provider. If the subscriber did not sign authorization for payment of medical Benefits, the subscriber may be responsible for paying all ~~of the~~ expenses up front and then requesting reimbursement from Us. We will not reimburse third parties who have purchased or been assigned Benefits by Physicians or other Providers.

Required Information for Claims

When You request payment of Benefits from Us, You must provide Us with all of the following information:

1. The Subscriber's name and address;
2. The patient's name and age;
3. The number stated on Your ID card;
4. The name, address, phone number and Tax ID of the provider of the service(s);
5. A diagnosis from the Physician;
6. An itemized bill from the provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge;
7. The date the Injury or Sickness began;
8. A statement indicating ~~either~~ whether You are, or You are not, enrolled for coverage under any other health insurance plan or program. If You are enrolled for other coverage, You must include the name of the other carrier(s), the name and date of birth of the subscriber for that coverage and the effective date of the coverage..

Proof of Loss

Written proof of such loss and notice of claim must be provided to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within such time will ~~not~~neither invalidate nor reduce any claim, if it was not reasonably possible to furnish such proof within such time. In no event, except in the absence of legal capacity of the claimant, will a claim be valid later than one (1) year from the time proof is otherwise required. All Benefits payable under the Policy will be paid within thirty (30) days after receipt of proof. Written proofs of claim must be furnished to the Plan at P.O. Box 4568, Springfield, MO 65808.

Time of Payment of Claims

Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim. All eligible reimbursement will be payable to ~~Network~~ Providers. ~~Reimbursement for services received from an Non-Network Provider will be paid to the insured, unless You provide Us with a written assignment of Benefits form signed by You, allowing payment directly to the Non-Network Provider.~~ We will send You an Explanation of Benefits form or letter. This will show You what services were paid, how much was paid, who was paid, when payment was made, or why payment for some services was not made or was made in part. There may be some circumstances for which We must seek additional information from You to process the claim. We will suspend (pend) the claim for up to thirty (30) days to give You ample time to respond. If You fail to respond within the thirty (30) days, the claim will be denied. If You present the information after the thirty (30) days allocated, the claim will be reprocessed in accordance to

the terms and Benefits of Your coverage. If We deny all or any part of Your claim, We will send You an Explanation of Benefits form or a letter telling You why it was denied. The form or letter may also tell You what other information, if any, We would need to reconsider Our decision. If You do not agree with Our decision, You have the right to appeal Your claim. See Section 8 (Complaints, Grievances and Appeals). You may also call or write Us, or You may contact the Arkansas Insurance Department.

Action on Claims

If a claim is denied, We will send You a written notice that contains the reason for the denial and information on Your right to appeal. If You believe there is a discrepancy between the Benefits, the Policy, and the processing of such claim, or if You have a Grievance, You must notify the Plan no later than one-hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to a Grievance. If a claim is denied, You may obtain a review of the denial through the Complaint and Grievance Procedure. See Section 8 (Complaints, Grievances and Appeals).

Release of Records

During the processing of Your claim, We might need to review Your health records. As a ~~e~~Covered ~~p~~Person, You hereby authorize the release to Us of all health records related to Your claim. This release constitutes authorization of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality under the terms of applicable privacy laws. This authorization also applies to any Covered Dependent under this Policy.

Direct Payment to Public Hospitals

Benefits for Covered Health Services will be paid, with or without an assignment from You, to public hospitals or clinics for services and supplies provided to You, if proper claim is submitted by the public hospital or clinic. No Benefits will be paid under this Section to the public hospital or clinic, if such Benefits have been paid to You prior to Us receiving Your claim. Payment to the public hospital or clinic will discharge Us from all liability to You to the extent of the Benefits so paid.

Section 8: Complaints, Grievances & Appeals

These procedures address all Complaints, Grievances, and appeals from Members concerning operation of the Plan, **except** any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment.

A Member, a Member's ~~designee~~authorized representative, or a Provider can make a Complaint or Grievance at any time. Complaints can be about anything, including: the Plan's service, Utilization Review, or a provider's service. A Complaint or Grievance can always be directed to the Arkansas Insurance Department at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
1-800-852-5494

Step	Description
1	**What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.** Customer Contact Center Representatives are available to take Your call during regular ~~working~~business hours, 8:00 AM – 5:00 PM, Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below. The Plan agrees to investigate, and endeavor to resolve, any and all ~~c~~Complaints received from Members with regard to the nature of professional services rendered, or Benefits provided, under thisPolicy. ~~Any inquiries, Complaints or the like will be~~Oral complaints or inquiries can be made to the Plan by telephone or an arranged appointment ~~to~~with the Customer Contact Center Representative at: Mercy Health Plans ATTN: Customer Contact Center 14528 S. Outer 40, Suite 300 Chesterfield, Missouri 63017-5743 866-450-3249 The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your rightful access to review through the formal Grievance Process.
2	**Ask Us in writing to reconsider Our initial decision.** ***Minimum Time to File a Grievance:*** You must file a Grievance no later than one hundred eighty (180) days from the date that written notice was sent from the Plan, informing You of the event that gave rise to the Grievance. ~~***First Level***~~ ***Grievance Procedure:*** Ask Us in writing to reconsider Our initial decision. You, Your authorized representative, or Your Provider can submit a Grievance described below. a) Write to Us no later than one hundred eighty (180) days from the date that written notice was sent from the Plan to You, informing You of the event that gave rise to the Grievance; b) Send Your request to ~~Us at~~: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743; c) Include a statement about why You believe Our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical

records, and Explanation of Benefits (EOB) forms.

The Plan will acknowledge receipt of Your Grievance in writing within ten (10) working days. A complete investigation of the Grievance will follow. Someone who is neither the individual who made the initial determination, nor the subordinate of such individual will conduct the review.

In the case of a Grievance involving a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual.

We will notify You of Our determination in writing as follows:

- Within ~~fifteen~~thirty (~~15~~30) calendar days for a service You have not yet received pre-service; or
- Within ~~thirty~~sixty (~~3~~60) calendar days for a service You have already received post-service.

This written determination will include information about Your right to ~~file an appeal~~request an External Independent Review~~,~~ (if We maintain Our denial of an Adverse Determination) and Your right to other voluntary alternative dispute resolution..

3 ~~**Ask Us in writing to reconsider Our Grievance decision. This is called an Appeal.**~~

~~***Minimum Time to File a Grievance:*** A second level Grievance (called an "appeal") may be filed no later than one hundred eighty (180) days from the date the Plan sent You a resolution of Your first level Grievance.~~

~~***Second Level Grievance/Appeal Procedure:*** To appeal a denial regarding Your first level Grievance, You, Your authorized representative, or Your Provider must:~~

~~a)Write to Us no later than one hundred eighty (180) days from the date We sent You written resolution of Your first level Grievance;~~

~~b)Send Your request to Us at: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743; and~~

~~c)Include a statement about why You believe Our decision was wrong based on specific benefit provisions in this brochure.~~

~~When We receive Your appeal, it will be submitted to a Grievance Advisory Panel consisting of other enrollees and representatives of the Plan that were not involved in the circumstances giving rise to the Grievance, or in any subsequent investigation or determination of the Grievance; and, when the Grievance involves an Adverse Determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the Grievance, or in any subsequent investigation or determination of the Grievance. Review by the Grievance Advisory Panel will follow the same time frames as the first level Grievance review.~~

~~We will write to You with Our decision.~~

Expedited Grievance Procedure: When the standard time frames of the Grievance procedure would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) working days of the notification of the determination.

~~***Expedited Grievance/Appeal Procedure:*** When the standard time frames in the Complaint, Grievance and appeal procedures would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) working days of the notification of the determination~~

4 ***Ask Us for an External Independent Review, only if Your appeal was related to an Adverse Determination.***

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External ~~Independent~~ Review. A request for a standard External Review must be made in writing, and should include any information or documentation to support Your

request for the covered service. **Note: Only appeals that are related to an Adverse Determination and that involve treatment, services, equipment, supplies, or drugs that would require the Plan to expend $500 or more of expenditures are afforded an External Independent Review.**

"Adverse Determination" means a determination by the Plan that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested health care service does not meet the Plan's requirements for medical necessity, or

(b) The requested health care service has been found to be "Experimental/Investigational."

The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the External Independent Review organization selected to perform the review. For the purposes of this Section, an External Independent Reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the case; and (c) have not been informed of the specific identity of the Member.

The independent review organization will complete its review within forty-five (45) calendar days after the receipt of the request for an External Review and will provide a written notice of its decision to You, or Your authorized representative, and the Plan.

An expedited External Independent Review may be requested for a situation when a delay would significantly increase the risk to Your health or when extended health care services for a course of treatment that You are undergoing is at issue. Upon submission of a request for expedited External Independent Review, the Plan will immediately assign an independent review organization approved by the Arkansas Insurance Department. The independent review organization shall make a determination and verbally notify You, or Your authorized representative, and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the independent reviewer is final. Within two (2) calendar days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

5 At any time, You have the right to contact the Arkansas Insurance Department 's consumer complaint hotline at: **1-800-852-5494** regarding Your grievance, or write to the Arkansas Insurance Department at the following address: **Arkansas Insurance Department, Consumer Services Division, Third and Cross Streets, Little Rock, AR 72201**.

Section 9: Utilization Review

The following is information pertaining to Utilization Review decisions and procedures. Please note that in addition to Utilization Reviews, Mercy Health Plans' practices Case Management, and therefore may provide You with information about additional services that are available to You such as disease management programs, health education, pre-admission counseling and patient advocacy.

Initial Determinations

For initial determinations, the Plan will make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this Section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an admission, procedure or service, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification.

In the case of an Adverse Determination, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the Adverse Determination; and will provide written or electronic confirmation of the telephone notification to You and Your provider within one (1) working day of making the Adverse Determination.

Concurrent Review Determinations

For concurrent review determinations, the Plan will make the determination within one (1) working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, the Plan will notify by telephone the provider rendering the service within one (1) working day of making the certification.

In the case of an Adverse Determination, the Plan will notify by telephone the provider rendering the services within twenty-four (24) hours of making the Adverse Determination, and provide written or electronic notification to You and Your provider within one (1) working day of the telephone notification.

Retrospective Review Determinations

For retrospective review determinations, the Plan will make the determination within thirty (30) working days of receiving all necessary information. The Plan will provide notice in writing of Our determination to You within ten (10) working days of making the determination.

Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. The Plan will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination, to any party who received notice of the Adverse Determination, and who requests such information.

Reconsideration of an Adverse Determination

In a case involving an initial determination or a concurrent review determination, the Plan will give the provider rendering the service an opportunity to request, on Your behalf, a reconsideration of an Adverse Determination by the reviewer making the Adverse Determination.

The reconsideration will occur within one (1) working day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the Adverse Determination, or a clinical peer designated by the reviewer who made the Adverse Determination (if the reviewer who made the Adverse Determination is not available within one (1) working day).

If the reconsideration process does not resolve the difference of opinion, You or Your provider may appeal the Adverse Determination. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an Adverse Determination.

Lack of Information

The Plan will have written procedures to address failure or inability of a provider or an enrollee to provide all necessary Information for review. In cases where the provider or an enrollee will not release necessary information, the Plan may deny certification of an admission, procedure or service.

Complaint and Grievance Procedures

These procedures address all Complaints, Grievances, and appeals concerning operation of Mercy Health Plans except any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment. The Complaint procedure is more fully described in Section 8 (Complaints, Grievances and Appeals).

Section 10: General Provisions

Your Relationship with Us

In order to make choices about Your health care coverage and treatment, We believe that it is important for You to understand how We interact with You. We help finance and administer the benefit plan in which You are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to You decisions about whether Your benefit plan will cover or pay for the health care that You may receive. The plan pays for certain medical costs, which are more fully described in this Policy. The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.
- We do not decide what care You need or will receive. You and Your Physician make those decisions.

We may use individually identifiable information about You to share with You (and You alone) procedures, products or services that You may find valuable. We will use individually identifiable information about You as permitted or required by law, in Our operations and in Our research. We will use de-identified data for commercial purposes, including research.

Our Relationship with You

The relationship between You and the Plan is solely a contractual relationship between independent contractors. You are not Our agent or employee. Neither We nor any of Our employees are Your agents.

We do not provide ~~h~~Health ~~c~~Care ~~s~~Services or supplies, nor do We practice medicine. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of Benefits under Your benefit plan.

You are solely responsible for all of the following:

- Enrollment changes (including the termination of Your coverage).
- The timely payment of the required ~~p~~Premium to Us.

Your Relationship with Providers

The relationship between You and any provider is that of provider and patient;

- You are responsible for choosing Your own provider;
- You must decide if any provider treating You is right for You~~;~~. This includes providers You choose and providers to whom You have been referred;

~~This includes providers You choose and providers to whom You have been referred;~~

- You must decide with Your provider what care You should receive;
- Your provider is solely responsible for the quality of the services provided to You.

Administrative Services

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Our sole discretion. We are not required to give You prior notice of any such change, nor are We required to obtain Your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, We reserve the right, in Our sole discretion and without Your approval, to change, interpret, modify, withdraw or add Benefits, or terminate the Policy.

Any provision of the Policy that on its Effective Date is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy, unless it is made by an Amendment or Rider that has been signed by one of Our officers. All of the following conditions apply:

- Amendments to the Policy are effective thirty-one (31) days after We send a written notice to the Enrolling Individual.
- Riders are effective on the date We specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Assignment

This Policy and all the rights, responsibilities and benefit payments under it are personal to You. You may assign them to any Provider of Covered Service.

Case Management

Case Management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family, and the attending physician to determine appropriate treatment options that will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation, or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to You or Your Dependent. In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive You of Benefits under the Policy, nor will it create a right to Benefits. If the Enrolling Individual makes a clerical error (including, but not limited to, sending Us inaccurate information regarding Your enrollment for coverage or the termination of Your coverage under the Policy) We will not make retroactive adjustments beyond a 60-day time period unless we are at fault. Our clerical errors or delays in keeping or reporting data relative to coverage will not terminate coverage which would otherwise be in force, nor continue coverage which would otherwise be terminated. Upon discovery of errors or delays, We will make whatever change is needed to assure that You have the coverage to which You are entitled to. No retroactive coverage or Premium changes will be made unless prior written approval is received from Us.

Conformity with State Laws

If any provision(s) of this Policy conflicts with Arkansas law, then those provision(s) are automatically changed to conform to at least the minimum requirements of the law.

Commission or Omission

No Hospital, Physician or other Provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other Providers or services or their agent or employee; or (4) You.

Entire Policy/Changes

The Policy issued to You, Your application, Amendments and any applicable Riders constitute the entire Policy. No change in this Policy will be valid until approved by one of Our executive officers, and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Examination of Covered Persons

In the event of a question or dispute regarding Your right to Benefits, We may require that a Network Physician of Our choice examine You at Our expense.

Incentives to Providers

We pay certain providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect Your access to health care.

Examples of financial incentives for providers are bonuses for performance based on factors that may include quality, Member satisfaction, and/or cost effectiveness.

We use various payment methods to pay specific providers. From time to time, the payment method may change. If You have questions about whether Your provider has a contract with Us and if that contract includes any financial incentives, We encourage You to discuss those questions with Your provider.

Incentives to You

Sometimes We may offer coupons or other incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is Yours alone, but We recommend that You discuss participating in such programs with Your Physician. These incentives are not Benefits and do not alter or affect Your Benefits. Contact Us if You have any questions.

Incorporation by Reference

Unless otherwise stated herein, the Schedule of Coverage and Benefits, the schedule of rates and ~~p~~Premiums, any riders, the application, and any amendments to any of the foregoing, form a part of this Policy as if fully incorporated herein.

Information and Records

At times, We may need additional information from You. You agree to furnish Us with all information and proofs that We may reasonably require regarding any matters pertaining to the Policy. If You do not provide this information when requested, We may delay or deny payment of Your Benefits.

By accepting Benefits under the Policy, You authorize and direct any person or institution that has provided services to You to furnish Us with all information or copies of records relating to the services provided to You. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents, whether or not they have signed the Subscriber's ~~application~~enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning Health Care Services that are necessary to implement and administer the terms of the Policy for appropriate medical review, quality assessment, or as We are required to do by law or regulation. During and after the term of the Policy, We and Our related entities ~~and We~~ may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of Your medical records or billing statements, We recommend that You contact Your health care provider. Providers may charge You reasonable fees to cover their costs for providing records or completing requested forms.

If You request medical forms or records from Us, We also may charge You reasonable fees to cover costs for completing the forms or providing the records.

In some cases, We will designate other persons or entities to request records or information from or related to You, and to release those records as necessary. Our designees have the same rights to this information as We have.

~~You will give Us information reasonably necessary to maintain Your records on a current basis. Failure to provide such information may terminate this Policy. Our clerical errors or delays in keeping or reporting data relative to coverage will not terminate coverage which would otherwise be in force, nor continue coverage which would otherwise be terminated. Upon discovery of errors or delays, We will make whatever change is needed to assure that You have the coverage to which You are entitled to. No retroactive coverage or Premium changes will be made unless prior written approval is received from Us. Retroactive changes beyond sixty (60) days will not be approved unless We are at fault.~~

Interpretation of Eligibility and Benefits

We have sole discretion to do all of the following:

- Determine eligibility;
- Interpret Benefits under the Policy;
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this Policy and any Riders and Amendments;
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case shall not in any way be deemed to require Us to do so in other similar cases.

Legal Actions

You may not bring any action of law or in equity concerning a claims payment until sixty (60) days after written proof of claim for Benefit payment has been furnished to Us, in accordance with the requirements of the Policy. Any such action must be filed within three (3) years of the date a claim is required to be sent to Us.

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Covered Persons who are eligible for or enrolled in Medicare may NOT be covered under the Policy.

Misstatement of Age

If the age of the insured has been misstated, all amounts payable under this Policy shall be equal to the amount that the ~~p~~Premium paid would have ~~been~~ purchased at the actual age when the policy was issued.

Notice

When We provide written notice regarding administration of the Policy to Your authorized representative, that notice is deemed notice to You and Your Enrolled Dependents.

Any notice required under this Policy will be sufficient if it is in writing, and mailed or delivered:

a) To You, when addressed to You at the address currently appearing on Our records; or
b) To Mercy Health Plans, when addressed to 14528 S Outer 40, Suite 300, Chesterfield, Missouri 63017-5743.

Policies, Identification Cards and Applications

We will furnish You with identification cards, copies of this Policy, and applications.

Reimbursement to Us

a) As a Covered Person, You agree to refund Us any benefit payment We made to You, or on Your behalf, for a claim paid or payable under Workers' Compensation or employers' liability law. Even if You fail to claim through a Workers' Compensation or employers' liability law, and You could have received payment through such a law if You had filed, reimbursement must still be made to Us. We have the right to credit payments of such claims against future claims in all cases.

b) We have the right to correct benefit payments paid in error. Hospitals, Physicians, other Providers and/or You have the responsibility to return any overpayment, including claims made involving fraud to Us. We have the responsibility to make additional payment if an underpayment is made.

Right of Reimbursement

In consideration of the coverage provided by this Certificate of Coverage, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us,
  - Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - Responding to requests for information about any accident or injuries,
  - Making court appearances, and
  - Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

Statements by Enrolling Individual or Subscriber

Except for fraudulent statements, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits, unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary.

Time Limit on Certain Defenses

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for charges incurred after the expiration of such three (3) year period.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by Workers' Compensation insurance.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
1. Ambulance Services- Emergency only	Medically Necessary ambulance service (either by a licensed ambulance service - ground or air ambulance) to the most appropriate Hospital where Emergency Care can be provided in the case of a Medical Condition and Medically Necessary transportation, however, use of air ambulance must be approved in advance or as soon as reasonably possible by the Plan. Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in emergency situations. See Section 12, ~~T~~R., for related exclusions.
2. Dental-Anesthesia and Facility Charges	Administration of general anesthesia and Hospital charges for dental care if: • The Covered Person is a child under the age of seven (7) who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or • The Covered Person is diagnosed with a serious mental or physical condition; or • The Covered Person has a significant behavioral problem as determined by the Plan. Limitations and Exclusions are described in Section 12, ~~E~~D. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits for dental anesthesia and related facility charges will be reduced by 50% of Eligible Expenses.
3. Diabetes Services	Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes. Coverage is provided for insulin infusion devices, insulin pumps, and associated supplies. Services for **diabetes self-management training**: Covered Health Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a licensed physician and a licensed health care professional must certify that the Covered Person successfully completed the training program. Coverage is limited to one(1) program during the entire time a Covered Person is Covered under this Certificate. A provider licensed, registered, and/or certified in the state to provide appropriate Health Care Services must provide diabetes self-management training program. Training is to be provided upon the initial diagnosis of diabetes, when there is a significant change in the Member's symptoms or when the Food and Drug Administration for the treatment of diabetes approve new techniques and treatments. **Prior Authorization Required** You must obtain Prior Authorization before receiving services for the following: ▪ Insulin pumps Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
4. Emergency Room Services	Emergency Room Services that are required to stabilize or initiate treatment in an Emergency. Emergency Room Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Room Services in Section 5 (How You Get Care).

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Physician charges may be applicable, if billed separately. See *Professional Fees for Surgical and Medical Services* below. Please remember that if You are admitted to a Hospital as a result of an Emergency, You must notify Us within two (2) working days or the same day of admission, or as soon as reasonably possible to receive authorization for continued services related to post-stabilization, as needed. If You don't notify Us, Benefits for the Hospital Inpatient Stay will be reduced to by 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services. Please refer to Hospital – Inpatient Stay below. If an Emergency Room admission results in a conversion to an Inpatient Stay or Observation Care, the Emergency room Copayment/Coinsurance charge will be waived when the hospital inpatient or observation admission for the same condition occurs within twenty-four (24) hours. The alternate higher level Copayment/Coinsurance will apply.
5. Hearing Screenings for Newborns	Newborn hearing screenings, necessary re-screening, audiological assessment and follow-up, and initial amplification.
6. Immunization – Routine Only	Routine immunizations as defined by the Plan. Coverage limitations may apply. Immunizations required for international travel are excluded. A list of routine immunizations can be obtained at **www.mercyhealthplans.com** or by calling Our Customer Contact Center at the number listed on Your ID card. There is no Copayment, Coinsurance or Deductible for routine immunizations. Applicable Copayments for office visit will apply. All other preventive health care services will be subject to Copayment, Coinsurance, Deductible, or dollar limit provisions.
7. Inpatient Hospital Services	Inpatient Hospital Services are available for: • Services and supplies received during the Inpatient stay. • Room and board in a Semi-private Room (a room with two or more beds), or 1. A private room only when medically necessary and approved in advance by the Plan. **Prior Authorization Required** Please remember that You must notify Us as follows: • For elective admissions; and 1. For Emergency admissions: within two (2) working days or the same day of admission, or as soon as is reasonably possible. Unless We pre-approve inpatient Hospital services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
8. In-Vitro Fertilization Services	Covered Health Services for In-Vitro Fertilization (IVF) include the following charges: • IVF associated lab; • Medication; • Imaging and procedures including female and male pre-testing; • The IVF process, and; • Cryopreservation.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Benefits are provided for in-vitro fertilization if the following conditions are met: • The patient's oocytes are fertilized with the sperm of the patient's Spouse, and • The patient and the patient's Spouse have a history of unexplained infertility of at least two (2) years' duration; or • The infertility is associated with one or more of the following medical conditions: • Endometriosis; • Exposure in utero to Diethylstilbestrol, commonly known as DES; • Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or • Abnormal male factors contributing to the infertility, and • The in-vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization. Any combination of Network and Non-Network Benefits is limited to a lifetime maximum benefit of $15,000 during the entire period of time You are covered under the Policy. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
~~8.~~9. **Maternity Services**	Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any related complications. Sonograms in uncomplicated pregnancies are limited to two per pregnancy. We will pay Benefits for an Inpatient Stay of: ~~o~~• _____ 48 hours for the mother and newborn child following a normal vaginal delivery. ~~o~~• _____ 96 hours for the mother and newborn child following a cesarean Section delivery. ~~o~~• _____ 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Early discharge requires that both of the following requirements are met: ~~o~~• _____ The discharge complies with the guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. ~~o~~• _____ The mother and child are provided post-discharge care as determined by the attending physician. Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician; and includes parent education, training in breast or bottle-feeding, and appropriate testing of the mother and child. Copayments and Deductible requirements apply to normal newborn admissions and both the mother and newborn will incur separate inpatient Copayments/Deductibles as follows: • If the mother and newborn are discharged from the same hospital on the same day, applicable Copayments/Coinsurances and Deductible will apply separately for the mother and the newborn;

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	however, the Deductible will be waived for the newborn; • If the mother and newborn are *not* discharged from the same hospital on the same day, both the mother and newborn will each incur applicable Copayments/Coinsurances and Deductibles for their inpatient hospital stay. The newborn's inpatient hospital Copayment/Coinsurance and Deductible will cover the dates of service *after* the mother's discharge, or dates of service at a different hospital. • If the newborn remains hospitalized after the mother's discharge date, an inpatient authorization is required for the dates of service after the mother's discharge date, and vice versa. See "Prior Authorization Required" below. **Note: The number of prenatal visits or change in Physician may effect Your Copayment/Coinsurance.** **Prior Authorization Required** Please remember that You must notify Us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. Unless We pre-approve any extended inpatient Hospital services beyond labor and delivery for either You or Your newborn, Your Network and Non-Network Benefits for the extended stay will be reduced by 50% of Eligible Benefits.
~~9.~~10. **Newborn Child Coverage**	Coverage for newborn children begins from the moment of birth. Benefits include coverage for illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, all other disorders of metabolism, and routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period. **Prior Authorization Required** We must be notified within ninety (90) days of birth, or Your next Premium due date, whichever is greater. If You don't notify Us, You will be responsible for paying 100% charges incurred after the lesser of five (5) days, or the mother's discharge date.
~~10.~~11. **Observation Care**	Observation Care are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services do not exceed one (1) day. Members may be admitted as Observation status to beds in the Emergency room, an observation unit, the intensive care unit, or a regular floor. If an Observation admission results in a conversion to an Inpatient Admission for the same condition within twenty (24) hours, the Observation Copayment will be waived. The alternate Copayment/Coinsurance will apply. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
~~11.~~12. **Osteoporosis Services/Bone Mineral Density (BMD) Testing**	Diagnosis, treatment, and appropriate management of osteoporosis for Covered Persons with a condition or medical history for which bone mass measurement is medically indicated. Coverage limitations may apply. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Center at the number listed on Your ID card. **Prior Authorization Required** Unless We pre-approve services requiring Prior Authorization, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
~~12.~~13. **Outpatient Diagnostic Services**	Covered ~~h~~Health ~~s~~Services received ~~on an outpatient basis at a Hospital or Alternate Facility for laboratory and medical diagnostic services.~~ on an outpatient basis at a Hospital or Alernate Facility for laboratory and medical diagnostic services. ~~1.~~• Laboratory servies; ~~2.~~• X-ray/imaging services; ~~3.~~• Other diagnostic tests and therapeutic treatments (including cancer Chemotherapy or intravenous infusion therapy). The following services are subject to the outpatient diagnostic charges regardless of the place of service: • MRA • MRI • CT Scan • PET Scan • Nuclear Cardiology Imaging studies Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on your ID card. ~~Benefits under this Section include only the facility charge and the charge for required services, supplies and equipment. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.~~ **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
~~13.~~14. **Outpatient Surgery/Hospital Procedures**	Covered surgical services and other medical care received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this Section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below, and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment. **Surgical Implants**, whether inserted in the inpatient, outpatient, or office setting, including pacemakers, stents, and other implantable devices or treatments. Copayment is consistent with type of service required. Implants for cosmetic or psychological reasons are excluded, see Section 12, ~~M~~L. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on your ID card. **Prior Authorization Required**

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
~~14.~~15. **Physician's Office Services**	Covered Health Services received in a Physician's office including: ~~o~~• Treatment of a Sickness or Injury; ~~o~~• Preventive medical care; ~~o~~• Well-baby and well-child care including children's preventive health care services for children from birth through eighteen (18) years of age; ~~o~~• Routine physical examinations.
~~15.~~16. **PKU/Medical Foods and Low Protein Modified Food Products for Metabolic Disorders**	Benefits are provided for Medical Foods and Low Protein Modified Food Products for Metabolic Disorders if the following are met: –• The Medical Food or Low Protein Modified Food Products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; –• The products are administered under the direction of a licensed physician; and –• The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the $2,400 per year per person. See Section 12, ~~K~~J. for limitations and exclusions related to this benefit.
~~16.~~17. **Preventive Health & Wellness Care**	Preventive Health Screenings are for non-symptomatic persons in accordance with the American Cancer Society guidelines and Mercy Health Plans' preventive health guidelines. Preventive Health Screenings include one (1) routine test of each of the following every ~~[~~Calendar~~]~~ ~~[Plan]~~ Year, unless otherwise indicated: • Cholesterol Tests • Colon Screening: – Colonoscopy – one (1) routine screening every ten (10) years – Double-contrast Barium Enema – one (1) routine screening every five (5) years – Flexible Sigmoidoscopy – one (1) routine screening every five (5) years – Fecal Occult Blood Test • Mammography • Pap Test • Pelvic Exam • Prostate Exam • PSA test [Preventive Health Screenings are covered in-Network with no Deductible. Deductible and Coinsurances will apply to services received from a Non-Network Provider.]
~~17.~~18. **Professional Fees for Surgical and Medical Services**	Professional fees for surgical procedures and other medical care provided in an outpatient facility. You may incur a separate copayment/coinsurance in addition to the outpatient facility charge. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
~~18.~~19. Reconstructive Procedures	Services for reconstructive procedures, when a physical impairment exists, and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. See Section 12, ~~M~~L. for related limitations and exclusions. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast disease, and reconstruction of the Non-affected breast to achieve symmetry. Reconstructive surgery for breast reconstruction and the receipt of a related prosthetic devices may follow a mastectomy at any time. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at the telephone number on Your ID card for more information about Benefits for mastectomy-related services. **Prior Authorization Required** You must notify Us before receiving services. When You notify Us, We can verify that the service is a reconstructive procedure, rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. Unless We pre-approve a Covered reconstructive Service, Network and Non-Network Benefits for reconstructive procedures will be reduced by 100% of Eligible Expenses.
~~19.~~20. Rehabilitation Services	***Outpatient Rehabilitation Therapy:*** Short-term outpatient rehabilitation services for: • Physical Therapy; • Occupational Therapy; • Speech Therapy; • Pulmonary Rehabilitation Therapy; • Cardiac Rehabilitation Therapy. Also includes covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for treatment for loss or impairment of speech or hearing. "Short-term" means rehabilitation services that are expected to result in significant physical improvement in Your condition within two (2) months of the start of treatment. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Home rehabilitation services are limited to the Homebound patient and considered separately under the home health Benefit. Please note that We will pay Benefits for Speech Therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Rehabilitation therapy services that are considered maintenance, developmental or educational in nature are not covered Benefits. Exclusions are described in Section 12, ~~R~~P. Any combination of Network and Non-Network Benefits is limited as according to Your Schedule of

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Coverage and Benefits. ***Inpatient Rehabilitation Services:*** Medically Necessary services for an Inpatient Stay in an Inpatient Rehabilitation Facility. Benefits are available for: ~~1.~~ • Services and supplies received during the Inpatient Stay ~~2.~~ • Room and board in a Semi-Private Room Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or non-elective inpatient rehabilitation admission. Unless We pre-approve inpatient rehabilitation services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For emergency admission, You must notify Us within two (2) working days or as soon as reasonably possible.
~~20.~~21. Skilled Nursing Facility (SNF)	Medically Necessary services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for: ~~3.~~ • Services and supplies received during the Inpatient Stay; ~~4.~~ • Room and board in a Semi-private Room. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or Non-elective admission. Unless we pre-approve SNF services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For emergency admissions, You must notify Us with two (2) working days or as soon as reasonably possible.
~~21.~~22. Urgent Care Center Services	Covered Health Services received at an Urgent Care Center. If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this Section.

Section 12: Exclusions – Things We Don't Cover

This Section contains information about Medical services that are not covered. We call these Exclusions. It's important for You to know what services and supplies are not covered under the Policy.

We do not pay Benefits for exclusions or any related complications.

We will not pay Benefits for any of the services, treatments, items or supplies described in this Section, even if either of the following is true:

~~1.~~ It is recommended or prescribed by a Physician.
~~2.~~ It is the only available treatment for Your condition.

The services, treatments, items or supplies listed in this Section are not Covered Health Services, except as may be specifically provided for in Section 11 (Covered Benefits) or through a Rider to the Policy.

Category	Description
A. Allergy	We do not cover any allergy related injections and serum, treatment, or testing.
B. Alternative Treatments	We do not cover alternative treatments, including but not limited to: 1. Acupressure and Acupuncture. 2. Aromatherapy. 3. Hypnotism. 4. Massage Therapy. 5. Rolfing. 6. Herbal remedies. 7. Ayurvedic therapies. 8. Reflexology. 9. Biofeedback and neurofeedback therapy. 10. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
~~**C.Chiropractic**~~	~~Under no circumstances will coverage be provided for:~~ ~~1.Services beyond the scope of the Network Chiropractor's license to practice chiropractic care.~~ ~~2.Services in excess of the chiropractic visit limitations indicated in Your Schedule of Coverage and Benefits.~~ ~~3.Preventive care services.~~ ~~4.Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders.~~ ~~5.Services that are not considered Medically Necessary and/or clinically appropriate.~~
~~**D.**~~**C. Comfort or Convenience**	1. Television. 2. Telephone. 3. Beauty/Barber service. 4. Guest service. 5. Automated travel devices (motor scooters). 6. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include: - Air conditioners - Air purifiers and filters - Batteries and battery chargers - Dehumidifiers and Humidifiers - Electrostatic machines - Lights/lighting - Portable room heaters, grab bars, etc. - Vaporizers - Tanning booths - Bath chairs - Breast pumps, unless newborn in NICU - Exercise equipment - Raised or regular toilet seats - Whirlpools, saunas, and hot tubs 7. Devices and computers to assist in communication and speech. Augmentative

Category	Description

communication devices, including, but not limited to, computer assisted speech devices, speech teaching machines, telephones, TDD equipment, Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, Non-digital voice systems, such as the Electro-Larynx, after post-radical neck or other invasive surgery that interferes with laryngeal function.

8. Personal hygiene items and hygienic items, including, but not limited to, shower chairs, commodes (unless the individual is confined to room or bed), incontinence pads, bed baths, etc.
9. Devices that are primarily non-medical in nature or used primarily for comfort, including, but not limited to:

- Bed boards
- Elevators
- Foam pads
- Heating pads
- Beds other than standard single hospital beds
- Overbed tables
- Carafes
- Emesis basins
- Maternity belts
- Bathtub seats
- Standing tables

10. Chair lifts, bathtub lifts, bed lifter, and other similar devices.
11. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.

~~E.~~D. Dental

1. Dental care, including Accidental Dental, except as described in Section 12 (Covered Benefits) under the heading, "Dental – Anesthesia and Facility Charges".
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following:
   - Extraction, restoration and replacement of teeth;
   - Medical or surgical treatments of dental conditions;
   - Services to improve dental clinical outcomes;
   - Services for overbite or underbite;
   - Services related to surgery for cutting through the lower or upper jaw bone;
   - Maxillary and mandibulary osteotomies
3. Dental implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded.
4. Dental braces and occlusal splints, even if associated with Accidental Dental Services.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   - Transplant preparation;
   - Initiation of immunosuppressives;
   - The direct treatment of acute traumatic Injury;
   - The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment);
   - Cleft palate;
   - Covered Persons with conditions outlined in Section 11 (Covered Benefits) under Dental – Anesthesia and Facility Charges;
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.
7. Orthodontic services.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer.

Category	Description
	10. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint syndrome, except as a treatment of obstructive sleep apnea.
~~E.~~E. **Drugs**	1. Prescription drug products for outpatient use (including self-injectables) that are filled by a prescription order or refill. 2. Non-injectable medications given in a Physician's office except as required in an Emergency. 3. Over the counter drugs and treatments. 4. Charges for supplies for use beyond the first twenty-four (24) hours following discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any prescription drugs intended primarily for home use. 5. Injectables/Infusions provided in a Physician's office, infusion center or through home health.
~~G.~~F. **Experimental, Investigational or Unproven Services**	1. Experimental, Investigational or Unproven Services are excluded including routine patient care costs for phase II, III or IV of clinical trials undertaken for the purpose of the prevention, early detection and treatment of cancer. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
~~H.~~G. **Foot Care**	1. Routine foot care (including the cutting or removal of corns and calluses). 2. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection. 3. Hygienic and preventive maintenance foot care. Examples include the following: – Cleaning and soaking the feet; – Applying skin creams in order to maintain skin tone; and – Other services that are performed when there is not a localized illness, Injury or symptom involving the foot. 4. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet, unless otherwise noted in this document. 5. Treatment of subluxation of the foot. ~~1.~~6. Shoe orthotics, orthopedic shoes and other supportive appliances for feet**.**
~~I.~~H. **Medical Supplies and Appliances**	1. Devices used specifically as safety items or to affect performance in sports-related activities. 2. Prescribed or Non-prescribed medical supplies and disposable supplies. Examples include: – Elastic stockings – Ace bandages – Gauze and dressings – Disposable sheets and bags – Fabric supports – Surgical face masks – Incontinent pads, including diapers – Irrigating kits – Pressure leotards – Surgical leggings and support hose Exceptions include diabetic supplies. 3. All orthotic and prosthetic devices/equipment except for breast prosthetics following a mastectomy. 4. Tubings and masks. 5. Devices and equipment that are not normally appropriate outside of a hospital (or other provider) setting, including, but not limited to: – Home monitoring devices and supplies, except Medically Necessary cardiac

Category	Description
	monitoring devices (such as holter monitors and event recorders) – Home prenatal monitoring and associated nursing support 6. Lift Seats. 7. DME is not covered except for Diabetes Services related equipment as described in Section 11 (Covered Benefits).
~~J.~~I. **Mental Health/Substance Abuse**	1. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders. 2. Psychosurgery. 3. Vagus nerve stimulation (VNS) for depression. 4. Residential treatment services.
~~K.~~J. **Nutrition**	1. Megavitamin and nutrition based therapy (for any purpose). 2. Vitamins (other than those prenatal vitamins prescribed for a Member who is then pregnant). 3. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except for treatment of Diabetes only. 4. Medical foods and other nutritional and electrolyte supplements taken orally, parenterally or enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any inherited disease of amino or organic acids. 5. Nutritional Supplements when tube feeding is the sole source of nutrition is also excluded.
~~L.~~K. **Personal**	1. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: a. Required solely for purposes of career, education, sports or camp, travel, recreation, employment, insurance, marriage or adoption. b. Related to judicial or administrative proceedings or orders. c. Conducted for purposes of medical research. d. Required to obtain or maintain a license of any type. 2. Custodial Care. See Section 13 (Definitions of Terms). *3.* Domiciliary care or any nursing care on full-time basis in Your home. 4. Private Duty Nursing. See Section 13 (Definitions of Terms). 5. Respite care. 6. Rest cures. 7. Medical and surgical treatment of excessive sweating (hyperhidrosis). 8. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. 9. Oral appliances for snoring. 10. Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony. 11. Work place evaluations and work hardening treatment. 12. Home Health Care Services. 13. Hospice/Pallative Care. 14. Tobacco Cessation education program and products. 15. Dialysis.
~~M.~~L. **Physical Appearance**	1. Cosmetic Procedures. See the definition in Section 13 (Definitions of Terms). Examples include: – Pharmacological regimens, nutritional procedures or treatments. – Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). – Skin abrasion procedures performed as a treatment for acne. – Liposuction. – Hair transplant for baldness. – Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears.

Category	Description
	– All other cosmetic services **except** if medically necessary to: i. Repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan; ii. Restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Member under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of normal human variation; or iii. Reconstructive breast surgery performed post-mastectomy. 2. Replacement of an existing breast implant, if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 11 (Covered Benefits). 3. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. 4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. 5. Wigs, regardless of the reason for the hair loss except as otherwise provided by law. 6. Treatment of benign gynecomastia (abnormal breast enlargement in males). 7. Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office visits associated with any weight loss program. 8. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded. 9. Sex transformation operations. 10. Breast Reduction Surgery (Reduction Mammoplasty).
~~**N.Pre-Existing Conditions**~~	~~Benefits for the treatment of a Preexisting Condition are excluded until the date You have been covered under this Policy for a period of twelve (12) months, except this waiting period will not apply to:~~ ~~1.A child who is placed in a Member's physical custody for purposes of adoption if the petition for adoption is filed within sixty (60) days of placement of such child; or~~ ~~2.A newborn if an application for coverage is filed within ninety (90) days of the birth of the child.~~ ~~3.~~1. ~~A person who has had creditable coverage for eighteen (18) months without a break of sixty-three (63) days or more.~~
~~O.~~**M.** **Providers**	~~O.~~1. Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. ~~P.~~2. Services performed by a provider with Your same legal residence. ~~Q.~~3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who *is* an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider: a. Has not been actively involved in Your medical care prior to ordering the service, or b. Is not actively involved in Your medical care after the service is received. This exclusion does not apply to mammography testing. ~~R.~~4. Charges Incurred for broken appointments with a Participating Physician.
~~P.~~**N.** **Reproduction**	1. Health services and associated expenses for Infertility treatments including, but not

Category	Description
	limited to, medical care or prescription drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, ~~in-vitro fertilization,~~ gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy. 2. Surrogate parenting. 3. Voluntary sterilization or the reversal of voluntary sterilization. 4. Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother. 5. Contraceptive supplies and services 6. Fetal reduction surgery. 7. Health services associated with the use of Non-surgical or drug induced Pregnancy termination. 8. Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function, unless otherwise covered in this Policy.
~~Q.~~O. **Services Provided under Another Plan**	1. Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. 2. Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by Workers' Compensation or similar law. If coverage under Workers' Compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under Workers' Compensation or similar legislation, if that coverage had been elected. 3. Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage, and facilities are reasonably available to You. 4. Health services while on active military duty. Upon notifying Mercy Health Plans of entry into military service, any pro-rata unearned premiums shall be refunded. 5. Injury or Illness incurred while incarcerated in any local, municipal, state or Federal facility.
~~R.~~P. **Therapies/Psychological Testing**	1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin (unless otherwise covered under this Policy, or by law). Speech Therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Cognitive therapy. 3. Psychological testing for any reason. 4. Neuropsychological Testing for any reason. 5. All Educational Services, including treatment of learning disorders and acquired cognitive deficits. 6. Water exercise and other exercises not under the supervision of a physical therapist. 7. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 8. Therapy for conditions such as developmental delay, ADHD, and autism.
~~S.~~Q. **Transplants**	1. Health services for organ and tissue transplants.

Category	Description
	2. Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. 3. Health services for transplants involving mechanical or animal organs.
~~T.~~R. Travel	1. Health services provided in a foreign country, unless required as Emergency Care Services. 2. Travel or transportation expenses, even though prescribed by a Physician, except for medically necessary ambulance services. 3. Air ambulance services outside the continental United States for any reason.
~~U.~~S. Vision and Hearing	1. Purchase cost of eye glasses, contact lenses (except for eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a $300.00 dollar benefit per lifetime), or hearing aids. 2. Fitting charge for hearing aids, eye glasses or contact lenses. 3. Eye exercise therapy (orthoptics or pleoptic training). 4. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery. 5. Routine eye examination by an ophthalmologist or optometrist for the correction of refractive errors.
~~V.~~T. General/ Administrative	1. Health services and supplies that are not included in Section 11 (Covered Benefits), or that do not meet the definition of a Covered Health Service - see the definition in Section 13 (Definitions of Terms). 2. Health services received as a result of any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country. 3. Health services received after the date Your coverage under the Policy ends, including health services for medical conditions arising before the date Your coverage under the Policy ends. 4. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. 5. Charges in excess of the Usual and Customary Rate (UCR) or in excess of any specified limitation. 6. Complications of Health Care Services that are not Covered Health Services. 7. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan. 8. Autopsies (post-mortem exams).

Section 13: Definitions of Terms

Adverse Determination

A decision by Mercy Health Plans that an admission, availability of care or continued stay has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness leading to a decision that coverage for the requested service is denied, reduced or terminated.

Alternate Facility

A health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

Amendment

Any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible/Deductible

If applicable, the amount You must pay for Covered Health Services in a [Calendar] [Plan] Year before We will begin paying for Benefits in that [Calendar] [Plan] Year. Deductible amounts are separate from and not reduced by Copayments. Deductible and Copayments are in addition to any ~~e~~Coinsurance You pay.

Benefits

Your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this Policy of Coverage and any attached Riders and Amendments.

Calendar Year

January 1 through December 31 of the same year.

Cardiac Rehabilitation

A comprehensive program to rehabilitate the heart.

Case Management

A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health Conditions. Case Management may include:

1. Assessment of Your individual benefit needs;
2. Formulation and modification of a comprehensive benefit plan of action;
3. Coordination of Benefits;
4. Evaluation of the effectiveness of the plan of action; and
5. Negotiation of extra-contractual services, if necessary.

Certificate of Coverage

This document including all Riders, Amendments and Schedule of Coverage.

Chemotherapy

Treatment of disease by FDA-approved antineoplastic agents.

Coinsurance

Coinsurance is the percentage of Our allowance that You must pay for Your care. You may also be responsible for other costs for Your care such as a Deductible. See Section 6 (Your Cost for Covered Services).

Complications of Pregnancy

Any complications associated with Pregnancy, i.e., conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest period during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Congenital Anomaly A physical developmental defect that is present at birth, and is identified within the first twelve (12) months of birth.

~~***Continuous Creditable Coverage***~~ ~~Health care coverage under any of the types of plans listed below, during which there was a break in coverage of no more than sixty-three (63) consecutive days, and provided there were eighteen (18) continuous months of eligible coverage:~~

- ~~A group or individual insured health plan.~~
- ~~Self-funded health plan coverage permitted by ERISA.~~
- ~~Medicare.~~
- ~~Medicaid.~~
- ~~Medical and dental care for Members and certain former Members of the uniformed services, and for their Dependents.~~
- ~~A medical care program of the Indian Health Services Program or a tribal organization.~~
- ~~A state health Benefits risk pool.~~
- ~~The Federal Employees Health Benefits Program.~~
- ~~Any public health benefit program provided by a state, county, or other public subdivision of a state.~~
- ~~A health benefit plan under the Peace Corps Act.~~

~~A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.~~

Copayment A Copayment is a fixed amount of money You pay when You receive ~~e~~Covered ~~s~~Services. See SSection 6 (Your Cost for Covered Services).

Cosmetic Procedures Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Us.

Covered Health Service(s)/Covered Services ~~A Covered Health Service is a Health Care Service or supply described in Section 12 (Covered Benefits) as a Covered Health Service.~~ A Covered Health Service is a Health Care Service or supply which is not excluded under Section 12 (Exclusions) and meets the following conditions:

1) Prescribed by a Physician for the therapeutic treatment of Injury, Illness or Complications of Pregnancy;
2) Deemed Medically Necessary and appropriate in type, level, setting, and length of service; and if required by the Plan, is authorized on a prospective and timely basis by the Plan's Medical Director.
3) Rendered in accordance with generally accepted medical practice and professionally recognized standards;
4) Provided on or after the Effective Date and before Your coverage terminates in accordance with Section 4 (When Coverage Ends) and at a time when You met all applicable requirements for eligibility set forth in Section 3 (When Coverage Begins).

~~5)Services that are specifically included and not excluded or limited, or not specifically excluded by the Plan.~~

Covered Person Either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "You" and "Your" throughout this Policy are references to a Covered Person.

Custodial Care Services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent The Subscriber's legal Spouse or an unmarried Dependent child of the Subscriber. The term

child includes any of the following:

- A natural child;
- A stepchild;
- A legally adopted child;
- A child placed for adoption;
- A child for whom permanent legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse.

To be eligible for coverage under the Policy, a Dependent's domicile and his/her primary residence must be in Arkansas. The definition of Dependent is subject to these conditions and limitations:

- A Dependent includes any unmarried dependent child under 19 years of age;
- A Dependent includes an unmarried dependent child who is 19 years of age or older to [23 – 25] years of age, only if You furnish evidence upon Our request, satisfactory to Us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Individual is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility

A Hospital that We name as a Designated Facility. A Designated Facility has entered into an agreement with Us, or with an organization contracting on Our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within Our geographic area.

Durable Medical Equipment (DME)

Medical equipment that is all of the following:

- Can withstand repeated use;
- Is not disposable;
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Is generally not useful to individuals in the absence of a Sickness, Injury or their symptoms;
- Is appropriate for use in the home.

Eligible Expenses

The amount We will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

Eligible Expenses are determined solely in accordance with Our reimbursement policy guidelines. We develop Our reimbursement policy guidelines, in Our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications.
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that We accept.

Eligible Person

An Eligible Person is a Subscriber or Dependent that was covered under the [group] Policy this conversion Policy replaces on the date of termination of such group Policy. An Eligible Person's

domicile and his/her primary residence must be located within Arkansas. In addition, an Eligible person is not/cannot be covered by Medicare, or by another health insurance policy, whether individual or group, or by similar benefits provided by any state or federal law.

Emergency

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but will not be limited to, any of the following:

- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain;
- With respect to a pregnant woman who is having contractions, either of the following:
  - Inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery;
  - The transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Care/Emergency Room Services

Health Care Services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent

A Dependent who is properly enrolled under the Policy.

Enrolling Individual

The individual to whom the Policy is issued.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

External Independent Reviewer

A clinical peer with no direct financial interest in connection with the Grievance/appeal in question and who has not been informed of the specific identity of the Enrollee.

External Review

A process, independent of all affected parties, to determine if a Health Care Service is medically necessary or Experimental/Investigational.

Full-Time Student

An unmarried dependent child who is between the ages of 19 – 23 that meets all the following conditions:

- The child must not be regularly employed on a full-time basis;
- The child must be primarily dependent upon the Subscriber for support and maintenance;
- The child must be attending, fulltime, a recognized course of study or training at one of the following:
  - An accredited high school;
  - An accredited college or university;
  - A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student on the date You graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If You do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Grievance

A written Complaint submitted by or on behalf of a Member regarding the a) availability, delivery or quality of Health Care Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; b) claims payment, handling or reimbursement for Health Care Services; or c) matters pertaining to the contractual relationship between a Member and the Company.

Health Care Service(s)

Those health services provided for cosmetic or other non-medical purposes, or for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

Homebound

Homebound means an individual who is confined to the home as a result of their physical or mental condition and that leaving home is a major effort and normally requires assistance. Leaving home is done to receive medical care or for short, infrequent non-medical reasons such as a trip to the grocery store, beauty parlor or barbershop, or to attend religious services.

Hospital

A legally constituted institution, having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facilities are operated as a separate institution by a hospital.

Implant(s)

That which is implanted such as a piece of tissue, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purpose. Examples of ~~such~~surgical Implants include stents, artificial joints, shunts, grafts pins, plates, screws, anchors and radioactive seeds.

Infertility

The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful ~~p~~Pregnancy. (Sexual intercourse means the sexual union between a male and female). Infertility does not include individuals unable to conceive post sterilization.

Initial Enrollment Period

The initial period of time, ~~as We agree with the Enrolling Individual,~~ during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury

Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility	A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.
Inpatient Stay	An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.
Low Protein Modified Food Products	Food products specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.
Maximum Policy Benefit	The maximum amount that We will pay for Benefits during the entire period of time that You are enrolled under the Policy issued to the Enrolling Individual. The Maximum Policy Benefit includes any amount that We have paid for Benefits under a former Policy issued to the Enrolling Individual that is replaced by the current Policy, as well as any amount that We may pay under a later Policy that replaces the Enrolling Individual's current Policy. When the Maximum Policy Benefit applies, it is described in Section 6 (Your Cost for Covered Services).
Medical Foods	Products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.
Medically Necessary	Health Care Services that are ordered by a Health Provider, without which there would be significant risk of a serious deterioration and/or a significant impairment that, if not treated, could seriously affect one's ability to function within his or her normal environment. Although some Health Care Services are medically acceptable, they may not be medically necessary. Health Care Services need to be (1) medically appropriate and necessary to meet the basic health needs of the Member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; (4) consistent with the diagnosis of the conditions; and (5) of demonstrated medical value. Medically Necessary does not include care that is provided primarily for the convenience of the Member or a Health Provider, or care that is rendered more frequently than that accepted as medically appropriate by the medical profession.
Medicare	Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.
Member	A Member means any Subscriber or Dependent.
Mental Illness	Those Conditions classified as mental disorders in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, except mental retardation
Network Benefits	Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network provider in the provider's office or at a Network or Non-Network facility.
Network/Network Provider	When used to describe a provider of Health Care Services, this means a provider that has a participation agreement in effect with Us or with Our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons. A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of Our products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement, and a Non-Network provider for other Health Services and products. The participation status of providers will change from time to time.
Neuropsychological Testing	Neuropsychological Testing is a quantitative, comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain

disorders.

Non-Network Benefits — Benefits for Covered Health Services that are provided by a Non-Network Physician or other Non-Network provider.

Observation Care — Care in the Hospital to monitor evaluate or stabilize a patient in order to determine the need for further treatment or an inpatient admission. Such Care is not considered Inpatient Care, even though the patient may be confined to a Hospital bed.

Occupational Therapy — Treatment of a physically or mentally disabled person through constructive activities designed to restore the ability to accomplish satisfactorily the ordinary activities of daily living. Activities of daily living include feeding, dressing, bathing and other types of self-care.

Out-of-Pocket Maximum — If applicable, the maximum amount of Coinsurance You pay every ~~[~~Calendar~~]~~ ~~[Plan]~~ Year. If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that ~~[~~Calendar~~]~~ ~~[Plan]~~ Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that ~~[~~Calendar~~]~~ ~~[Plan]~~ Year. See Section 6 (Your Cost for Covered Services).

Physical Therapy — Treatment by physical means including hydrotherapy, heat, physical agents, and biomechanical and neurophysiological principles and devices that relieve pain or restore maximum bodily function. Physical Therapy does not include Cardiac Rehabilitation, Pulmonary Rehabilitation or Manipulation/Adjustment.

Physician — Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that We describe a provider as a Physician does not mean that Benefits for services from that provider are available to You under the Policy.

~~***[Plan Year]***~~ — ~~[Means the period of twelve (12) months commencing on the Effective Date of this Agreement and each twelve (12) month period thereafter (or other periods as indicated in the Individual Enrollment Agreement), unless otherwise terminated as provided herein.]~~

Policy — This document including all riders, Amendments and Schedule of Coverage.

Policy Charge — The sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy — Includes all of the following:

- Prenatal care;
- Postnatal care;
- Childbirth.~~;~~

~~Any complications associated with Pregnancy, i.e., conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest period during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.~~

Premium — The periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with

the terms of the Policy.

Prior Authorization Precertification review by the Plan, before services and treatment are rendered, to determine if the service meets the criteria as a Covered Health Service.

Preventive Health Screening(s) Routine tests performed on a healthy individual who has no signs or symptoms of disease, or history of the disease being screened. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient or a patient previously diagnosed with the disease being screened are classified as diagnostic tests. Diagnostic tests will incur Deductibles and/or Copayments/Coinsurances consistent with the services received.

Private Duty Nursing Private Duty Nursing is defined as one-on-one care provided on an individual basis either in an institution or in a patient's home. Private duty skilled nursing care can be considered custodial after Non-professional personnel repetitively performs the care, making continuous attention by a health professional no longer necessary, and is therefore not a covered benefit.

Pulmonary Rehabilitation A comprehensive program to manage patients with substantial chronic lung disease. Includes diagnostic testing, monitored dynamic exercise and education under the direct supervision of a qualified Physician.

Rider Any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-Private Room A room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Health Service, the difference in cost between a Semi-Private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.

Sickness Physical illness, disease or Pregnancy. The term Sickness as used in this Policy does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal Care, Custodial Care, ambulatory Care, part-time Care, or Care for Mental Illness and Substance Abuse, pulmonary tuberculosis or venereal disease.

Speech Therapy Treatment for loss or impairment of speech or hearing, including communicative disorders resulting from genetic defects, birth defects, injury, illness, disease, developmental disabilities or delays or other causes, whether of organic or nonorganic etiology and whether or not the person suffering from that loss or impairment had the capacity for speech, language or hearing before the loss or impairment occurred.

Subscriber An Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued.

The Plan The Plan refers to Mercy Health Plans.

Unproven Services Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a Individual of patients who receive standard therapy.

- The comparison Individual must be nearly identical to the study treatment Individual.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Urgent Care Center

A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of Your health, within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Us/We/Our

Us/We/Our refers to Mercy Health Plans.

Usual and Customary Rate (UCR)

Charges for Covered Health Services which do not exceed the fees and prices generally approved for cases of comparable nature and severity at the time and place when such Covered Services are rendered or received. In determining the Usual and Customary Rate (UCR), the following guidelines shall be taken into consideration:

a) The rate allowed by Medicare for that particular service or supply~~usual fee which the individual health professional most frequently charges for a service or supply~~;
b) The prevailing rate of fees charged for identical or similar services in the same geographical area by health professionals of similar training and experience;
c) Unusual circumstances or complications that require additional time, skill and experience in connection with the provided service or supply;
d) The actual charge by the Provider (if less than Our UCR charge);
~~d)~~e) The frequency of the determination of the usual and customary fee;
~~e)~~f) A general description of the methodology used to determine usual and customary fees;
~~f)~~g) The percentile that determines the maximum benefit the Plan will pay for any Accidental Injury dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then making the benefit by selecting a percentile of those fees.

Utilization Review

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of Health Care Services, procedures or settings. Utilization Review may include Ambulatory Review, Prospective Review, second opinion, Certification, Concurrent Review, Case Management, ~~D~~discharge ~~P~~planning or Retrospective Review, but will not include elective requests for clarification of Coverage.

You/Your

You/Your refers to the Subscriber and each Enrolled Dependent.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MHP, Inc. by and on behalf of its wholly-owned subsidiaries, including Mercy Health Plans of Missouri, Inc., Mercy Health Plans, and Premier Benefits, Inc. (Collectively referred to as "the Plan"), respects the privacy of its Members and former Members and protects the security and confidentiality of their nonpublic personal information. We have instituted internal policies to: insure the security and confidentiality of Your personal and financial healthcare information; protect against any anticipated threats of hazards to the security or integrity of such records; and protect against unauthorized access to or use of information which could result in substantial harm or inconvenience to You. We are required by law to provide You with this Notice of Our legal duties and privacy practices. This Notice explains Your rights, Our legal duties, and Our privacy practices. To fulfill Our responsibilities to You, the Plan may use and disclose Your protected health information for treatment, payment, and healthcare operations, or when We are otherwise required or permitted to do so by law. Below is further detail explaining these situations.

TREATMENT
We may use and disclose protected health information with Your healthcare providers (physicians, pharmacies, hospitals and others) to assist in the diagnosis and treatment of Your injury or illness. For example, We may disclose Your protected health information to suggest treatment alternatives.

PAYMENT
We may use and disclose protected health information to pay for Your covered health expenses. For example, We may use protected health information to process claims. We may also ask a healthcare provider for details about Your treatment so that We may pay the claim for Your care.

HEALTHCARE OPERATIONS
We may use and disclose protected health information for Our healthcare operations. For example, We may use or disclose protected health information to perform quality assessment activities or provide You with case management services.

BUSINESS ASSOCIATES
We may, at times, need to use the services of other companies in lieu of Our own staff, such as outsourcing data entry services, or, as part of Our routine business, We may require that outside entities, such as auditors perform operations that require access to Our healthcare information. In order for Us to share confidential information with these organizations, We must enter into agreements that require them to comply with the privacy regulations of the Plan.

YOU OR YOUR PERSONAL REPRESENTATIVE
We must disclose Your health information to You as described in the Patient Rights Section below. If You have a legally-assigned personal representative or are an un-emancipated minor, We will release the information to Your personal representative or parent(s) as required by law.

FAMILY/FRIENDS
We may disclose Your health information to a family member or friend to the extent necessary to help with Your healthcare or with payment for Your healthcare, if You agree that We may do so. If You wish to designate a person(s) to whom We may discuss Your healthcare, You may submit a request to the address listed below. If You are physically or mentally unable to participate in decisions regarding Your healthcare, We may need to communicate with a family member; however, only to the extent necessary to insure that You receive appropriate healthcare treatment.

PERMITTED OR REQUIRED BY LAW
We must disclose protected health information about You when required to do so by law. Information about You may be used or disclosed to regulatory agencies, such as Medicare and Medicaid; for administrative or judicial hearings; public health authorities; or law enforcement officials, such as to comply with a court order or subpoena.

MEMBER AUTHORIZATION
Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding protected health information that the Plan maintains about You. If You wish to exercise any of these rights, You may submit Your request in writing.

- Right to Access Your Protected Health Information. You have the right to inspect and/or obtain a copy of individual protected health information that We maintain about You. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance.

- Right to Amend Your Protected Health Information. You have the right to request an amendment of individual protected health information that We maintain about You. All requests must be in writing and must include the reason for the change.

- Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of disclosures of individual protected health information made by the Plan on or after the compliance date of April 14, 2003. All requests must be in writing and must state the period of time for which You want the accounting. We may charge for providing the accounting, but We will tell You the cost in advance.

- Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that the Plan restrict the use and disclosure of Your protected health information for treatment, payment, or healthcare operations. The Plan is not required to agree to the requested restriction; however, if the Plan does agree to the restriction, it must comply with Your request, unless the information is needed for an emergency.

- Right to Receive Confidential Communications. You have the right to request to receive communication of protected health information from the Plan through an alternative procedure (other than the standard means of communicating protected health information). All requests must be in writing and are subject to technical reasonability for the Plan.

- Right to a Paper Copy of This Notice. You have the right at any time to receive a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.

CHANGES

The Plan reserves the right to change the terms of this Notice at any time, effective for protected health information that We already have about You as well as any information that We receive in the future. We are required by law to comply with whatever Notice is currently in effect. We will communicate changes to Our Notice through subscriber newsletters, direct mail and/or Our Internet website (www.mercyhealthplans.com).

COMPLAINTS

If You believe Your privacy rights have been violated, You have the right to file a complaint with the Plan and/or with the Federal Government. Complaints to the Plan may be directed to the appropriate Customer Contact Center listed at the end of this Notice or by calling the Customer Contact Center number listed on the back of Your ID card. You may also file a complaint anonymously by calling the Plan's Fraud and Abuse Hotline at 1-877-349-5997. Complaints to the government may be sent to: Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.

CONTACT THE PLAN

If You want more information about this Notice, how to exercise Your rights, or how to file a complaint, please direct Your correspondence to the appropriate Customer Contact Center listed at the end of this Notice or call the Customer Contact Center phone number listed on the back of Your ID card. You can also contact Us through Our Internet website: www.mercyhealthplans.com

Mercy Health Plans
ATTN: Customer Contact Center
14528 S Outer 40, Suite 300,
Chesterfield, MO 63017-5743

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for Your policy, contract or any portion of it that is not guaranteed by the insurer, or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverage, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act, or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);

- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a non-affiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance Benefits, $300,000 in present value of annuity Benefits, or $300,000 in life insurance death Benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity Benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those Benefits could be provided out of the assets of the impaired or insolvent insurer.

SCHEDULE OF COVERAGE AND BENEFITS
for
[NAME]
Effective Date of Coverage [MM/DD/YYYY]

With Mercy Health Plans' conversion Policy, You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network ~~p~~Provider. You must show Your identification card (ID card) every time You request health care services from a ~~Network p~~Provider. ~~If You do not show Your ID card, Network providers have no way of knowing that You are enrolled under a Mercy Health Plans' Policy. As a result, they may bill You for the entire cost of the services You receive.~~

Please refer to Your Policy for a detailed explanation of covered and non-covered services~~complete description of Your Benefits.~~ In some cases, You must notify Us before receiving services.

PAYMENT INFORMATION	AMOUNT	
	NETWORK	NON-NETWORK
MEDICAL SERVICES **Annual Deductible**	[$500 - $2,500] per Covered Person per Calendar Year, not to exceed $3,000 for all Covered Persons in a family.	[$1,000 - $5,000] per Covered Person per Calendar Year, not to exceed $6,000 for all Covered Persons in a family.
Out-of-Pocket Maximum *Coinsurance is the amount You pay after You meet Your Deductible. All Coinsurances apply towards Your Out-of-Pocket Maximum, except those related to Covered Health Service contained in an optional Rider.* **Out-of-Pocket Maximum does not include the Annual Deductible.**	**Network and Non-Network** [$1,000 after Deductible per individual per Calendar Year, not to exceed $3,000 for all Covered Persons in a family.] [No Out-of-Pocket Maximum]	**Non-Network** No Out-of-Pocket Maximum
Maximum Policy Benefit	**Network and Non-Network Combined** $250,000 per Covered Person	

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
1. Ambulance Services - Emergency Only • Ground Transportation • Air Transportation ✸	*Ground Transportation:* 20% Coinsurance after Deductible *Air Transportation:* 45% Coinsurance after Deductible per transport	*Ground Transportation:* 45% Coinsurance after Deductible *Air Transportation:* 45% Coinsurance after Deductible
2. Dental Anesthesia and Facility Charges ✸ Coverage is limited to: • A Covered Person who is a child under the age of seven (7) who is determined by two (2) dentists to require necessary dental treatment; or • A Covered Person who is severely disabled; or • A Covered Person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.	20% Coinsurance after Deductible	45% Coinsurance after Deductible

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK

✸ Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

3. Diabetes Services ✸ Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes.	20% Coinsurance after Deductible Copayment/Coinsurance consistent with type of service required.	45% Coinsurance after Deductible
4. Emergency Room Services Physician charges may be applicable, if billed separately. See *Professional Fees for Surgical and Medical Services* below. Copayment/Coinsurance charge will be waived when hospital inpatient or observation admission for the same condition occurs within twenty-four (24) hours.	[$0 - $250 Copayment per visit] [20% Coinsurance after Deductible]	[$0 - $250 Copayment per visit] [45% Coinsurance after Deductible]
5. Hearing Screenings for Newborns	20% Coinsurance after Deductible	45% Coinsurance after Deductible
6. Immunization - Routine Only (Received in Physician's Office)	20% Coinsurance after Deductible for adults over 18 yrs. No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.	45% Coinsurance after Deductible. No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.
7. Inpatient Hospital Services ✸ Semi-Private Room covered.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
~~7.~~**8. In-Vitro Fertilization ✸** Covered Health Services for In-Vitro Fertilization (IVF) include the following: • IVF associated labs; • Medication; • Imaging and procedures including female and male pre-testing; • The IVF process, and; • Cryopreservation. Any combination of Network and Non-Network Benefits for in-vitro fertilization is limited to a lifetime maximum $15,000.	20% Coinsurance after Deductible Member is responsible for the remaining 100% of the charges for infertility services over $15,000.	45% Coinsurance after Deductible Member is responsible for the remaining 100% of the charges for infertility services over $15,000.]
~~8.~~**9. Maternity Services ✸**	*Physician Office*: 20% Coinsurance after Deductible No Copayment applies to Physician office visits for prenatal care after the first visit. *Hospital Outpatient- Observation*: 20% Coinsurance after Deductible per visit *Hospital Inpatient Services*: 20% Coinsurance after Deductible *Outpatient Laboratory services:* 20% Coinsurance after Deductible *Outpatient X-ray/Imaging:* 20% Coinsurance after Deductible	*Physician Office:* 45% Coinsurance after Deductible *Hospital Outpatient- Observation*: 45% Coinsurance after Deductible *Hospital Inpatient Services*: 45% Coinsurance after Deductible *Outpatient Laboratory services:* 45% Coinsurance after Deductible *Outpatient X-ray/Imaging:* 45% Coinsurance after Deductible
~~9.~~**10. Newborn Child Coverage ✸**	20% Coinsurance after Deductible	45% Coinsurance after Deductible

✸ Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
~~10.~~11. **Observation Care** ✸ If an Observation admission results in a conversion to an Inpatient Admission, the Observation Copayment will be waived. The alternate Copayment/Coinsurance will apply.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
~~11.~~12. **Osteoporosis Services/Bone Mineral Density (BMD) Testing** ✸ Diagnosis, treatment, and appropriate management of osteoporosis are covered for persons with a condition or medical history for which bone mass measurement is medically indicated. When these services are performed in a Physician's office, Physician's charges may apply. See *Physician's Office Services* below. A list of osteoporosis services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling our Customer Contact Center at the number listed on Your ID card.	*Laboratory Services*: 20% Coinsurance after Deductible *X-ray/Imaging:* 20% Coinsurance after Deductible *Other Diagnostic/Therapeutic Services*: 20% Coinsurance after Deductible	*Laboratory Services*: 45% Coinsurance after Deductible *X-ray/Imaging:* 45% Coinsurance after Deductible *Other Diagnostic/Therapeutic Services*: 45% Coinsurance after Deductible
~~12.~~13. **Outpatient Diagnostic Services** ✸ Covered ~~h~~Health ~~s~~Services received on an outpatient basis at a Hospital or Alternate Facility include: • Laboratory services • X-Ray/Imaging • Other diagnostic & therapeutic services The following services are subject to the outpatient diagnostic charges regardless of the place of service: • MRA • MRI • CT Scan • PET Scan • Nuclear Cardiology Imaging studies.~~When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.~~ A list of diagnostic/imaging services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling our Customer Contact Center at the number listed on Your ID card.	Laboratory Services ~~(Not performed in a Physician's office)~~: 20% Coinsurance after Deductible ~~Laboratory Services (Performed in a Physician's office): 20% Coinsurance after Deductible~~ X-Ray/Imaging ~~(Not performed in a Physician's office) and all other Diagnostics:~~ 20% Coinsurance after Deductible ~~X-Ray/Imaging (Performed in a Physician's office): 20% Coinsurance after Deductible~~ Other Diagnostic & therapeutic services: 20% Coinsurance after Deductible	Laboratory Services ~~(Not performed in a Physician's office)~~: 45% Coinsurance after Deductible ~~Laboratory Services (Performed in a Physician's office): 45% Coinsurance after Deductible~~ X-Ray/Imaging ~~(Not performed in a Physician's office) and all other Diagnostics~~: 45% Coinsurance after Deductible ~~X-Ray/Imaging (Performed in a Physician's office): 45% Coinsurance after Deductible~~ Other Diagnostic & therapeutic services: 45% Coinsurance after Deductible
~~13.~~14. **Outpatient Surgery/Hospital Procedures** ✸ Coverage includes surgical services and hospital procedures received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for required	Outpatient Surgery/Hospital Procedures: 20% Coinsurance after Deductible per outpatient surgery or procedure	45% Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment. • Surgical Implants Implants for cosmetic or psychological reasons are excluded, see Section 12, M. in Your Policy.	Surgical Implants*:* [Copayment consistent with type of service received]. [20%] [45%] Coinsurance after Deductible]]	Surgical Implants*:* [Copayment consistent with type of service received]. [45% Coinsurance after Deductible]
~~14.~~15. **Physician's Office Services**	20% Coinsurance after Deductible ~~No Copayment for immunizations for children from birth to age eighteen (18).~~	45% Coinsurance after Deductible ~~No Copayment for immunizations for children from birth to age eighteen (18).~~
~~15.~~16. **PKU/Medical Foods and Low Protein Modified Food Products for Metabolic Disorders** Please refer to Your Policy Section 11 (Covered Benefits) for limitations.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
~~16.~~17. **Preventive Health & Wellness Care** Services may be performed in a Physician's office or an outpatient facility and may incur both a professional fee and/or outpatient facility charges. Coinsurance will be consistent with type of service received. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient diagnostic services are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Physician's charges may apply. See *Physician's Office Services* above.	*Cholesterol Tests:* [0% -45%] Coinsurance after Deductible *Colon Screening:* [0% - 45%] Coinsurance after Deductible *Well-Woman:* [0% - 45%] Coinsurance after Deductible *Prostate Exam:* [0% - 45%] Coinsurance after Deductible *PSA test:* [0% - 45%] Coinsurance after Deductible *Diabetes A1C Test:* [0% - 45%] Coinsurance after Deductible *Osteoporosis Services:* [0% - 45%] Coinsurance after Deductible	[Covered In-Network only]
~~17.~~18. **Professional Fees for Surgical and Medical Services**	20% Coinsurance after Deductible	45% Coinsurance after Deductible
~~18.~~19. **Reconstructive Procedures** ✸ Please refer to Your Policy Section 11 (Covered Benefits) for limitations.	20% Coinsurance after Deductible	45% Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
~~19.~~20. **Rehabilitation Services** Outpatient Rehabilitation Therapy Any combination of Network and Non-Network Benefits is limited as follows: ▪ 60 Combined visits per Calendar Year for Physical, Occupational and Speech Therapy ▪ 36 Visits of Pulmonary Rehabilitation Therapy within a 12-week period per [Calendar] [Plan] Year. ▪ 36 Visits of Cardiac Rehabilitation Therapy within a 12-week period per [Calendar] [Plan] Year. Inpatient Rehabilitation Services ✸ Any combination of Network and Non-Network Benefits is limited up to a maximum of [60 – 120] days per [Calendar] [Plan] Year. Rehabilitation Therapy services that are considered maintenance, developmental or educational in nature are not covered Benefits.	Outpatient Rehabilitation Therapy Physical Therapy/Occupational Therapy/Speech Therapy: 20% Coinsurance after Deductible Pulmonary Rehabilitation: 20% Coinsurance after Deductible Cardiac Rehabilitation: 20% Coinsurance after Deductible Inpatient Rehabilitation Services [0% - 45%] Coinsurance after Deductible] [$0 - $5,000] per Inpatient Stay] [$0 - $1,000] Copayment per day] [$0 - $1,000] Copayment per day to a maximum of [$0 - $5,000] Copayment per Inpatient Stay]	Outpatient Rehabilitation Therapy 45% Coinsurance after Deductible Inpatient Rehabilitation Services [0% - 45%] Coinsurance after Deductible
~~20.~~21. **Skilled Nursing Facility (SNF)** ✸ Any combination of Network and Non-Network Benefits is limited to [60-120] days per Calendar Year.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
~~21.~~22. **Urgent Care Center Services** Covered Health Services received at an Urgent Care Center that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. If radiology and other diagnostic services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply.	[$0 - $250 Copayment] per visit] [No Copayment] [20% Coinsurance after Deductible]	[$0 - $250 Copayment] per visit] [0% - 45%] Coinsurance after Deductible

OPTIONAL RIDERS		
[Temporomandibular Joint Disorder (TMJ)] [When these services are performed in a Physician's office, Benefits are described under *Physician Office Services* above.] [Coinsurance consistent with applicable inpatient hospital, outpatient, hospital or other services required.]	NETWORK [0% - 50%] Coinsurance after Deductible	NON-NETWORK [0% - 50%] Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

Section 4: When Coverage Ends

General Information about When Coverage Ends:

- We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.
- Your entitlement to Benefits automatically ends on the date that coverage ends, even if You are hospitalized or are otherwise receiving medical treatment on that date.
- When Your coverage ends, We will still pay claims for Covered Health Services that You received before Your coverage ended. However, once Your coverage ends, We do not provide Benefits for health services that You receive for medical conditions that occurred after Your coverage ended.
- An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends except in the event of the Subscriber's death.

Events Ending Your Coverage

Your coverage ends on the earliest of the dates specified in the following outline:

Event	Description
The Entire Individual Policy Ends	Your coverage ends on the date the Individual Policy ends. The Plan is responsible for notifying You that Your coverage has ended.
You Are No Longer Eligible for Coverage	Your coverage ends on the date You are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 2 (Eligibility) and Section 13 (Definitions of Terms) for more information. **When You turn age 65 or become eligible for Medicare, or ~~are covered~~have full coverage by a similar health insurance plan (group or individual) which provides benefits for all preexisting conditions, or are eligible for similar benefits provided by state or federal laws, You are no longer eligible for this conversion coverage.** If ~~y~~Your coverage ends due to Your death and ~~w~~We receive notification within one (1) year of Your death, ~~p~~Premiums paid for coverage beyond the date of Your death will be refunded to You or ~~y~~Your estate within thirty (30) days after We receive written proof of Your death. In the event of the Subscriber's death, and upon notification to the Plan, coverage may continue for Eligible Spouse and/or Dependents who were covered by the Group Policy on the date of termination of insurance.
We Receive Notice to End Coverage	Your coverage ends at the end of the month that We receive Your request in writing. We must receive Your termination notice **prior** to Your requested date of termination. Your Conversion Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period.
Fraud, Misrepresentation or False Information	Your coverage ends on the date We identify, in a notice, that Your coverage is terminated because of fraud or misrepresentation. We will provide written notice to the Subscriber that coverage has ended. During the first three (3) years the Policy is in effect, if You provided Us with false information or misrepresentation of material facts regarding Your application or coverage, We have the right to demand that You pay back all Benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under the Policy. After the first three (3) years, We can only demand that You pay back these Benefits if the written application contained a fraudulent

Event	Description
	misstatement.
Abuse of Services or Facilities	In the event of abuse by a Covered Person in the use of services or facilities, that person's coverage may be restricted or canceled by the Plan upon at least thirty-one (31) days' prior written notice to the ~~Individual and the~~ Member.
~~**Death of Subscriber**~~	~~Coverage ends for the Subscriber and his/her Dependents as of the date of the Subscriber's death.~~
Improper Use of ID Card	Your coverage ends when You permit an unauthorized person to use Your ID card, or You used another person's card. When Your coverage is terminated because of improper use of Your ID card, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice.
Misconduct	In the event Your misconduct is detrimental to the safe Plan operations and the delivery of services, Your coverage may be cancelled immediately.
Moving Out of State	Coverage will end within sixty (60) days after We receive notice of Your move out of Arkansas.
Non-Payment of Premiums	This Policy will automatically end on the last day of the period for which Premiums have been paid. If Premiums are not paid within the grace period, thirty-one (31) days from the premium due date, there will be no reinstatement.

SERFF Tracking Number:	*MHPL-125742797*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*39777*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*PHIARCONVCOC (08)*		
Project Name/Number:	*/*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Conversion Policy	07/22/2008	AR Conversion_COC_FINAL 07.18.08.pdf
No original date	Form	Schedule of Coverage	07/22/2008	AR Conversion Schedule_07.22.08.pdf

Your Individual Conversion Policy

Issued by: Mercy Health Plans

This Individual Conversion Policy is guaranteed renewable

NOTICE:

The Benefits in this Policy do not necessarily equal or match those Benefits provided in Your previous group Policy

This Health Plan is underwritten by Mercy Health Plans. The Benefits and main points of coverage under the Plan are set forth in this Individual Conversion Policy and Schedule of Coverage and Benefits and any attached Riders. The Benefits are effective only while You are covered by this conversion Policy. The Benefits in this Policy do not necessarily equal or match those benefits provided in your previous group Policy.

This Policy describes the Benefits for health care services provided by Mercy Health Plans and the extent to which Benefit Payment may be limited. The Policy may be terminated by Mercy Health Plans or by You as described in this Policy.

You may return this Policy within ten (10) days of its receipt for full refund of any Premiums paid if, after examining it, You are not satisfied for any reason. Written notification is required to return this Policy. If services are utilized during this (10) day period, this policy is assumed to be accepted. Any coverage returned for a refund of premium will be null and void from its inception.

Mercy Health Plans
14528 S Outer 40, Suite 300
Chesterfield, Missouri 63017
314-214-8100
800-830-1918
www.mercyhealthplans.com

Table of Contents

Individual Health Conversion Policy

The Individual Health Conversion Policy is a legal document between **Mercy Health Plans** (**"The Plan", "We", "Us", "Our"**) and **the Enrolling Individual** (**"You", "Your"**) to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrollee's application and payment of the required Policy premium within thirty (30) days after termination from Your group health policy.

The Policy includes:

- The Enrollee's application;
- Any Amendments and Riders;
- The Schedule of Coverage and Benefits.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens We will send You the revised Policy, Rider or Amendment pages.

No one has the authority to make any changes to the Policy unless those changes are in writing and signed by an officer of Mercy Health Plans. No change shall be valid until approved and made part of the Policy. Only the Plan has the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without Your approval.

Information You Should Have

This Policy describes Benefits in effect as of Effective Date of Policy Issuance.

On its Effective Date, this Policy replaces and overrules any Policy that We may have previously issued to You, or Your employer. This Policy will in turn be overruled by any Policy We issue to You in the future.

Coverage under the Policy will begin at 12:01 a.m. on the Effective Date and end at 12:00 midnight on the Termination Date. The Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to termination of the Policy.

This Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

We are delivering the Policy in the State of Arkansas. The laws of the State of Arkansas govern this Policy.

The validity of the Policy will not be contested after the Policy has been in force for three (3) years from the date of issue. No statement relating to insurability, made by any person covered under the Policy, will be used to contest the validity of the Policy after it has been in force for a period of three (3) years. In addition, the statement must be contained in a written instrument signed by the person making the statement. The assertion, at any time, of defenses based upon the person's ineligibility for coverage under the Policy, or upon other provisions in the Policy, will not be precluded.

Section 1: Introduction to Your Policy

We encourage You to read Your Policy and any attached Riders and/or Amendments carefully.

Information about Defined Terms

Because this Policy is part of a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in Section 13 (Definitions of Terms). You can refer to Section 13 as You read this document to have a clearer understanding of Your Policy of Coverage.

When We use the words **"The Plan"**, **"We", "Us", and "Our"** in this document, We are referring to **Mercy Health Plans.** When We use the words **"You" and "Your",** We are referring to people who are **Covered Persons** as the term is defined in Section 13 (Definitions of Terms).

This Policy and the other Policy documents describe Your Benefits as well as Your rights and responsibilities under the Policy.

We especially encourage You to review the Benefit limitations of this Policy by reading Section 11 (Covered Benefits) and Section 12 (Exclusions). You should also carefully read Section 10 (General Provisions) to better understand how this Policy and Your Benefits work. You should call Us if You have questions about the coverage available to You.

Many of the Sections of the Policy are related to other Sections of the document. You may not have all of the information You need by reading just one Section. We also encourage You to keep Your Policy and any attachments in a safe place for Your future reference.

Please be aware that Your Physician does not have a copy of Your Policy of Coverage, and is not responsible for knowing or communicating Your Benefits.

Required Premiums, Premium Changes and Grace Period

The Plan requires payment of premiums by the 15th of each month for this Policy. You must pay the required premium within a 31-day grace period to keep this Policy in force. All premiums must be paid via any one of the following methods:

- ACH Direct Debit Program
- Credit Card payment
- A Check for the entire annual Premium

Your Conversion Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

Upon the payment of a claim under this Policy, any Premium then due and unpaid or covered by any note or written order may be deducted from the claim payment. We may change the amount of Your Premiums on any monthly due date upon giving You sixty (60) days prior written notice.

We may change the terms and conditions of this Policy to conform to the laws of the State of Arkansas, to conform to Federal law or to conform to underwriting policies established by Mercy Health Plans, after submission to and approval by the Arkansas Insurance Department. For changes in terms and conditions, We must give written notice thirty (30) days before the change. This notice may be in the form of a new Policy, or a Rider or Amendment to this Policy.

Don't Hesitate to Contact Us

Throughout the document You will find statements that encourage You to contact Us for further information. Whenever You have a question or concern regarding Your Benefits, please call Us using the telephone number for Our Customer Contact Center listed on Your ID card.

Section 2: Eligibility

How to Enroll

If Eligible, the Enrolling Individual must complete an enrollment application and submit the properly completed form to Us, along with any required Premium within thirty (30) days after termination of Your group health policy. We will not provide Benefits for health services that You receive before Your Effective Date of coverage.

If You Are Hospitalized When Your Coverage Begins

If You are a patient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the effective date of this Policy, We will pay Benefits for Covered Health Services related to that Inpatient Stay as long as You receive Covered Health Services in accordance with the terms of the Policy.

If You are hospitalized when Your coverage begins, You should notify Us within forty-eight (48) hours of Your effective date, or as soon as is reasonably possible. Network Benefits are available only if You receive Covered Health Services from Network Providers.

Who is Eligible for Coverage?

To be eligible for this coverage, Your primary domicile must be within Arkansas.

A converted policy need not be made available if termination occurred for any of the following reasons:

- You failed to make timely payment of any required contribution.
- The Group Policy terminated or a group's participation terminated, and the insurance is replaced by similar coverage under another Group Policy within thirty-one (31) days of the date of termination.

Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under your group Policy.

The converted policy shall cover the employee or Member and his/her Dependents who were covered by the Group Policy on the date of termination of insurance.

Who is Not Eligible to Enroll?

We are not required to issue a converted policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted policy covering any person if:

- Such person is or could be covered for similar benefits by another individual policy;
- Such person is or could be covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured, or similar benefits are provided for or available to such person, by reasons of state or Federal law; and
- The benefits under sources of the kind referred to above for such person, or benefits provided or available under sources of the kind referred to above for such person, together with the converted policy's benefits would result in over-insurance according to the insurer's standards for over-insurance.

Persons not eligible for coverage include –

a) Those whose coverage was previously terminated for the following causes:
    - Fraud or misrepresentation in the application;
    - Abuse of services or facilities;
    - Improper use of ID Card;
    - Misconduct detrimental to Plan operations and the delivery of services;
    - Failure to pay Premiums more than twice in the past 12 months, or to pay Premiums in a timely manner in accordance with the terms of the Policy.

Refer to Section 4 (When Coverage Ends) for a detailed description of these causes that lead to termination.

Section 3: When Coverage Begins

Initial Enrollment Period

The Initial Enrollment Period is the first time You enroll Yourself and/Your eligible Dependents, subject to acceptance by the Plan. Coverage begins on the Effective Date as determined by the Plan and when We approve Your completed application and receive the required Premium. Only a Subscriber or Dependent that was covered under the group Policy this conversion Policy replaces on the date of termination of such group Policy are Eligible to enroll in this Policy.

Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is Totally Disabled because of a mental or a physical disability will not end just because the child has reached a certain age. We will extend the coverage for the disabled child beyond the limiting age if both of the following are true:

- The disabled child is not able to be self-supporting because of a mental or physical disability; **and**
- The disabled child depends primarily on the Subscriber for support and maintenance due to the mental or physical disability.

Coverage will continue as long the Enrolled Dependent is disabled and continues to satisfy both of these qualifying conditions, unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask You to furnish Us with proof of the disabled child's incapacity and dependency within a reasonable time after the date coverage would otherwise have ended because the child reached a certain age. Before We agree to this extension of coverage for the child, We may require that a Physician chosen by Us examine the child. We will pay for that examination.

We may continue to ask You for proof that the disabled child still meets these two conditions, but will not ask more than once per year. The proof We ask for might include medical examinations at Our expense.

If You do not provide proof acceptable to Us of the disabled child's incapacity and dependency, as described above, coverage for that child will end.

Section 4: When Coverage Ends

General Information about When Coverage Ends:

- We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.
- Your entitlement to Benefits automatically ends on the date that coverage ends, even if You are hospitalized or are otherwise receiving medical treatment on that date.
- When Your coverage ends, We will still pay claims for Covered Health Services that You received before Your coverage ended. However, once Your coverage ends, We do not provide Benefits for health services that You receive for medical conditions that occurred after Your coverage ended.
- An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Events Ending Your Coverage

Your coverage ends on the earliest of the dates specified in the following outline:

Event	Description
The Entire Individual Policy Ends	Your coverage ends on the date the Individual Policy ends. The Plan is responsible for notifying You that Your coverage has ended.
You Are No Longer Eligible for Coverage	Your coverage ends on the date You are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 2 (Eligibility) and Section 13 (Definitions of Terms) for more information. **When You turn age 65 or become eligible for Medicare, or are covered by a similar health insurance plan (group or individual), or are eligible for similar benefits provided by state or federal laws, You are no longer eligible for this conversion coverage.** If your coverage ends due to Your death and we receive notification within one (1) year of Your death, premiums paid for coverage beyond the date of Your death will be refunded to You or your estate within thirty (30) days after We receive written proof of Your death.
We Receive Notice to End Coverage	Your coverage ends at the end of the month that We receive Your request in writing. We must receive Your termination notice **prior** to Your requested date of termination. Your Conversion Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period.
Fraud, Misrepresentation or False Information	Your coverage ends on the date We identify, in a notice, that Your coverage is terminated because of fraud or misrepresentation. We will provide written notice to the Subscriber that coverage has ended. During the first three (3) years the Policy is in effect, if You provided Us with false information or misrepresentation of material facts regarding Your application or coverage, We have the right to demand that You pay back all Benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under the Policy. After the first three (3) years, We can only demand that You pay back these Benefits if the written application contained a fraudulent misstatement.

Event	Description
Abuse of Services or Facilities	In the event of abuse by a Covered Person in the use of services or facilities, that person's coverage may be restricted or canceled by the Plan upon at least thirty-one (31) days' prior written notice to the Individual and the Member.
Death of Subscriber	Coverage ends for the Subscriber and his/her Dependents as of the date of the Subscriber's death.
Improper Use of ID Card	Your coverage ends when You permit an unauthorized person to use Your ID card, or You used another person's card. When Your coverage is terminated because of improper use of Your ID card, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice.
Misconduct	In the event Your misconduct is detrimental to the safe Plan operations and the delivery of services, Your coverage may be cancelled immediately.
Moving Out of State	Coverage will end within sixty (60) days after We receive notice of Your move out of Arkansas.
Non-Payment of Premiums	This Policy will automatically end on the last day of the period for which Premiums have been paid. If Premiums are not paid within the grace period, thirty-one (31) days from the premium due date, there will be no reinstatement.

Section 5: How You Get Care

Identification cards

We will send You an identification (ID) card when You enroll. You should carry Your ID card with You at all times. You must show it whenever You receive services from a Network Provider. If You do not show Your ID card, Network Providers have no way of knowing that You are enrolled under Our Conversion Policy. As a result, they may bill You for the entire cost of the services You receive.

If You do not receive Your ID card within thirty (30) days after the Effective Date of Your enrollment, or if You need replacement cards, call Us at 866-647-5568. You must show Your ID card every time You request Health Care Services from a Network Provider.

Where You get covered care

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Individual Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 4 (When Coverage Ends) occurs.
- The person who received Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

You will only pay Copayments, Deductibles, and/or Coinsurances when receiving care from a Network Provider for a Covered Health Service. If You use Non-Network Providers, it will cost You more.

Network Providers

Network Providers are physicians and other health care professionals that We contract with to provide Covered Services to Our Members. Network Providers are independent practitioners. They are not Our employees. It is Your responsibility to select Your provider. We credential Network Providers according to national standards. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

A directory of Network Providers is available on our website at www.mercyhealthplans.com We update the provider directory periodically. However, before obtaining services You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Our Customer Contact Center at 866-647-5568.

It is possible that You might not be able to obtain services from a particular Network Provider. The Network of providers is subject to change. You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of Our products. Refer to Your provider directory or contact Us for assistance.

Extended Provider Network

Mercy Health Plans has an extended provider network **outside** of Our contracted network called Private Healthcare Systems Preferred Provider Organization (PHCS PPO). This extended Provider Network is available to You as Network Benefits only when you are **outside** of Our contracted network. To find a PHCS PPO provider, call Our Customer Contact Center or visit www.phcs.com and select the PPO Network.

PHCS PPO Network is not available when you receive services **within** Mercy Health Plans' contracted network.

Network Benefits

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services that are described as Network Benefits in Section 11 (Covered Benefits) and are any of the following:

- Provided by a Network Physician or other Network Provider.
- Emergency Room Services.

Designated Facilities and Other Providers

If You have a medical condition that We believe needs special services, We may direct You to a Designated Facility or other Network Provider chosen by Us. Network Benefits will only be paid if Your Covered Health Services for that condition are provided by, or arranged by the Network Designated Facility, or other Network Provider chosen by Us. Non-Network Benefits will apply to any Non-Network facility or provider.

Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by Non-Network Physicians or Non-Network Providers.

What You must do to get covered care

You or Your physician must notify Us and obtain Prior Authorization before getting certain Covered Health Services from either Network or Non-Network Providers. However, **You are responsible for ensuring that Your provider obtains any required Prior-Authorization before You receive Covered Health Services.** A current list of those services and supplies requiring Prior Authorization is available by calling Our Customer contact Center at the telephone number listed on Your ID card, or by visiting www.mercyhealthplans.com. Verify with your Physician, or Our Contact Center, the authorized date range, and the number and type of services.

We urge You to confirm with Us that the services You plan to receive are Covered Health Services. Prior Authorization does not mean Benefits are payable in all cases. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before You receive treatment, You can check to see if the service is subject to limitations or exclusions including, but not limited to:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reconstruction; vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty;
- The Experimental, Investigational or Unproven Services exclusion;
- Any other contract limitation or exclusion.

FAILURE TO PREAUTHORIZE CERTAIN BENEFITS MAY RESULT IN A REDUCTION OF ELIGIBLE EXPENSES.

Care Management

When You notify Us as described above, We will work together to implement the Care Management process and to provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Room Services

We provide Benefits for Emergency Room Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Services, even if a Non-Network Provider provides the services. Emergency Services and any follow-up care rendered by a Non-Network Provider must be:

1. Of such immediate nature that Your health would be jeopardized if taken to a Network Hospital where the services of a Participating Physician would be available, or
2. Provided under circumstances under which You are unable, due to Your condition, to

request treatment at a location where the services of a Participating Physician would be available.

- If You are admitted as an inpatient to a Network or Non-Network Hospital after You receive Emergency Room Services, We must be notified within two (2) working days or on the same day of admission, or as soon as reasonably possible to receive authorization for continued services. Continuation of care as for any Inpatient Stay requires Prior Authorization and approval by the Plan.
- If You are admitted as an inpatient to a Non-Network Hospital after you receive Emergency Room Services, We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date We decide a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
- If You are admitted as an inpatient to a Network or Non-Network Hospital within twenty-four (24) hours of receiving treatment for the same condition as an Emergency Service, You will not have to pay the Copayment for Emergency Room Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

Urgent Care Services

Covered Health Services that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. Urgent Care is not the same as Emergency Care.

Section 6: Your Cost for Covered Services

This is what You will pay for covered care:

Copayments

A Copayment is a fixed amount of money You pay to the provider, facility, pharmacy, etc., when You receive *certain* services. **Copayments do not count towards Your Out-of-Pocket Maximum or Your Deductible.** Copayment amounts are listed on the Schedule of Coverage and Benefits next to the description for each Covered Health Service.

Coinsurance

Coinsurance is the percentage of Our Eligible Expenses that You must pay for Your care. Coinsurance doesn't begin until after You meet Your Deductible. **Only Coinsurances count toward Your Out-of-Pocket Maximum.**

Deductible

A Deductible is a fixed expense You must incur within a [Calendar Year] [Plan Year] for certain Covered Services and supplies before We start paying Benefits for them. For a complete definition of Annual Deductible, see Section 13 (Definitions of Terms).

NOTE: The Network Deductible does not apply to the Non-Network Deductible; also, the Non-Network Deductible does not apply to the Network Deductible.

Deductibles do not apply to Your Out-of-Pocket Maximum.

For Your Annual Deductible see Your Schedule of Coverage and Benefits.

Eligible Expenses

Eligible Expenses are the amount We determine that We will pay for Benefits minus any Copayment, Coinsurance or Deductible. We will pay a contracted rate for Network Providers. For Non-Network Providers, however, We will pay the Usual and Customary Rate (UCR) as determined by Us. For a complete definition of Eligible Expenses and UCR that describes how We determine payment, see Section 13 (Definitions of Terms).

Charges in Excess of the UCR

Charges by a provider in excess of UCR will not be covered under this Policy and wil not be counted toward Your Out-Of-Pocket Maximum limit or Deductible.

For Network Benefits, You are not responsible for any difference between the Eligible Expenses and the amount the provider bills, but You are responsible for all Copayments, Coinsurances or Deductibles.

For Non-Network Benefits, You are responsible to pay, directly to the Non-Network provider, any difference between the amount the provider bills You and the amount We will pay for Eligible Expenses. Please see Section 12 (Exclusions).

Out-of-Pocket Maximum

The maximum You pay out of Your pocket in a [Calendar] [Plan] Year for Coinsurances. For a complete definition of Out-of-Pocket Maximum, see Section 13 (Definitions of Terms).

If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that [Calendar] [Plan] Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that [Calendar] [Plan] Year.

The Out-of-Pocket Maximum does not include any of the following:

- Any charges for Non-Covered Health Services;
- Copayments/Coinsurance for Covered Health Services available by an optional Rider;
- The amount of any reduced Benefits if You don't obtain Prior Authorization as described in Section 11 (Covered Benefits);
- Charges that exceed Eligible Expenses;
- Any Copayments for Covered Health Services in Section 11 (Covered Benefits);
- The Annual Deductible.

For Your Annual Out-of-Pocket Maximum see Your Schedule of Coverage and Benefits.

Maximum Policy Benefit

The maximum amount We will pay for Benefits during the entire period of time You are enrolled under the Policy. For a complete definition of Maximum Policy Benefit, see Section 13 (Definitions of Terms).

For Your Maximum Policy Benefit see Your Schedule of Coverage and Benefits.

Section 7: How to File a Claim

Network Provider

We pay Network Providers directly for Your Covered Health Services. If a Network Provider bills You for any Covered Health Service, contact Us. However, You will be responsible for any Copayments or Coinsurance at the time of service.

Non-Network Provider

When You receive Covered Health Services from a Non-Network Provider, You may be responsible for paying for all expenses up front and then requesting reimbursement from Us.

How to File a Claim

While You do not need to fill out a specific claim form, You must file the claim in a format that contains all of the information We require, as described below.

If a Subscriber provides written authorization to a Non-Network Provider for payment of medical benefits for any Eligible Expenses, reimbursement may be paid directly to that Provider. If the subscriber did not sign authorization for payment of medical Benefits, the subscriber may be responsible for paying all of the expenses up front and then requesting reimbursement from Us. We will not reimburse third parties who have purchased or been assigned Benefits by Physicians or other Providers.

Required Information for Claims

When You request payment of Benefits from Us, You must provide Us with all of the following information:

1. The Subscriber's name and address;
2. The patient's name and age;
3. The number stated on Your ID card;
4. The name, address, phone number and Tax ID of the provider of the service(s);
5. A diagnosis from the Physician;
6. An itemized bill from the provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge;
7. The date the Injury or Sickness began;
8. A statement indicating either whether You are, or You are not, enrolled for coverage under any other health insurance plan or program. If You are enrolled for other coverage, You must include the name of the other carrier(s).

Proof of Loss

Written proof of such loss and notice of claim must be provided to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within such time will not invalidate nor reduce any claim, if it was not reasonably possible to furnish such proof within such time. In no event, except in the absence of legal capacity of the claimant, will a claim be valid later than one (1) year from the time proof is otherwise required. All Benefits payable under the Policy will be paid within thirty (30) days after receipt of proof. Written proofs of claim must be furnished to the Plan at P.O. Box 4568, Springfield, MO 65808.

Time of Payment of Claims

Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim. All eligible reimbursement will be payable to Network Providers. Reimbursement for services received from an Non-Network Provider will be paid to the insured, unless You provide Us with a written assignment of Benefits form signed by You, allowing payment directly to the Non-Network Provider. We will send You an Explanation of Benefits form or letter. This will show You what services were paid, how much was paid, who was paid, when payment was made, or why payment for some services was not made or was made in part. There may be some circumstances for which We must seek additional information from You to process the claim. We will suspend (pend) the claim for up to thirty (30) days to give You ample time to respond. If You fail to respond within the thirty (30) days, the claim will be denied. If You present the information after the thirty (30) days allocated, the claim will be reprocessed in accordance to the terms and Benefits of Your coverage. If We deny all or any part of Your claim, We will send You an Explanation of Benefits form or a letter telling You why it was denied. The form or letter may also tell You what other information, if any, We would need to

reconsider Our decision. If You do not agree with Our decision, You have the right to appeal Your claim. See Section 8 (Complaints, Grievances and Appeals). You may also call or write Us, or You may contact the Arkansas Insurance Department.

Action on Claims

If a claim is denied, We will send You a written notice that contains the reason for the denial and information on Your right to appeal. If You believe there is a discrepancy between the Benefits, the Policy, and the processing of such claim, or if You have a Grievance, You must notify the Plan no later than one-hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to a Grievance. If a claim is denied, You may obtain a review of the denial through the Complaint and Grievance Procedure. See Section 8 (Complaints, Grievances and Appeals).

Release of Records

During the processing of Your claim, We might need to review Your health records. As a covered person, You hereby authorize the release to Us of all health records related to Your claim. This release constitutes authorization of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality under the terms of applicable privacy laws. This authorization also applies to any Covered Dependent under this Policy.

Direct Payment to Public Hospitals

Benefits for Covered Health Services will be paid, with or without an assignment from You, to public hospitals or clinics for services and supplies provided to You, if proper claim is submitted by the public hospital or clinic. No Benefits will be paid under this Section to the public hospital or clinic, if such Benefits have been paid to You prior to Us receiving Your claim. Payment to the public hospital or clinic will discharge Us from all liability to You to the extent of the Benefits so paid.

Section 8: Complaints, Grievances & Appeals

These procedures address all Complaints, Grievances, and appeals from Members concerning operation of the Plan, **except** any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment.

A Member, a Member's designee, or a Provider can make a Complaint or Grievance at any time. Complaints can be about anything, including: the Plan's service, Utilization Review, or a provider's service. A Complaint or Grievance can always be directed to the Arkansas Insurance Department at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
1-800-852-5494

Step	Description

1 **What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.**

Customer Contact Center Representatives are available to take Your call during regular working hours, Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below.

The Plan agrees to investigate, and endeavor to resolve, any and all complaints received from Members with regard to the nature of professional services rendered, or Benefits provided, under thisPolicy. Any inquiries, Complaints or the like will be made to the Plan by telephone or arranged appointment to the Customer Contact Center Representative at:

Mercy Health Plans
ATTN: Customer Contact Center
14528 S. Outer 40, Suite 300
Chesterfield, Missouri 63017-5743
866-450-3249

The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your rightful access to review through the Grievance Process.

2 **Ask Us in writing to reconsider Our initial decision.**

Minimum Time to File a Grievance: You must file a Grievance no later than one hundred eighty (180) days from the date that written notice was sent from the Plan, informing You of the event that gave rise to the Grievance.

First Level Grievance Procedure: Ask Us in writing to reconsider Our initial decision. You, Your authorized representative, or Your Provider can submit a Grievance described below.

a) Write to Us no later than one hundred eighty (180) days from the date that written notice was sent from the Plan to You, informing You of the event that gave rise to the Grievance;

b) Send Your request to Us at: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743;

c) Include a statement about why You believe Our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms.

The Plan will acknowledge receipt of Your Grievance in writing within ten (10) working days. A complete investigation of the Grievance will follow. Someone who is neither the individual who made the initial determination, nor the subordinate of such individual will conduct the review.

In the case of a Grievance involving a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual.

We will notify You of Our determination in writing as follows:

- Within fifteen (15) calendar days for a service You have not yet received; or
- Within thirty (30) calendar days for a service You have already received.

This written determination will include information about Your right to file an appeal, if We maintain Our denial.

3 **Ask Us in writing to reconsider Our Grievance decision. This is called an Appeal.**

Minimum Time to File a Grievance: A second level Grievance (called an "appeal") may be filed no later than one hundred eighty (180) days from the date the Plan sent You a resolution of Your first level Grievance.

Second Level Grievance/Appeal Procedure: To appeal a denial regarding Your first level Grievance, You, Your authorized representative, or Your Provider must:

a) Write to Us no later than one hundred eighty (180) days from the date We sent You written resolution of Your first level Grievance;

b) Send Your request to Us at: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743; and

c) Include a statement about why You believe Our decision was wrong based on specific benefit provisions in this brochure.

When We receive Your appeal, it will be submitted to a Grievance Advisory Panel consisting of other enrollees and representatives of the Plan that were not involved in the circumstances giving rise to the Grievance, or in any subsequent investigation or determination of the Grievance; and, when the Grievance involves an Adverse Determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the Grievance, or in any subsequent investigation or determination of the Grievance. Review by the Grievance Advisory Panel will follow the same time frames as the first level Grievance review.

We will write to You with Our decision.

Expedited Grievance/Appeal Procedure: When the standard time frames in the Complaint, Grievance and appeal procedures would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) working days of the notification of the determination

4 ***Ask Us for an External Independent Review, only if Your appeal was related to an Adverse Determination***

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Independent Review. A request for a standard External Review must be made in writing, and should include any information or documentation to support Your request for the covered service. **Note: Only appeals that are related to an Adverse Determination and that involve treatment, services, equipment, supplies, or drugs that would require the Plan to expend $500 or more of expenditures are afforded an External Independent Review.**

"Adverse Determination" means a determination by the Plan that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested health care service does not meet the Plan's requirements for medical necessity, or

(b) The requested health care service has been found to be "Experimental/Investigational."

The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the External Independent Review organization selected to perform the review. For the purposes of this Section, an External Independent Reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the case; and (c) have not been informed of the specific identity of the Member.

The independent review organization will complete its review within forty-five (45) calendar days after the receipt of the request for an External Review and will provide a written notice of its decision to You, or Your authorized representative, and the Plan.

An expedited External Independent Review may be requested for a situation when a delay would significantly increase the risk to Your health or when extended health care services for a course of treatment that You are undergoing is at issue. Upon submission of a request for expedited External Independent Review, the Plan will immediately assign an independent review organization approved by the Arkansas Insurance Department. The independent review organization shall make a determination and verbally notify You, or Your authorized representative, and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the independent reviewer is final. Within two (2) calendar days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

5 At any time, You have the right to contact the Arkansas Insurance Department 's consumer complaint hotline at: **1-800-852-5494** regarding Your grievance, or write to the Arkansas Insurance Department at the following address: **Arkansas Insurance Department, Consumer Services Division, Third and Cross Streets, Little Rock, AR 72201**.

Section 9: Utilization Review

The following is information pertaining to Utilization Review decisions and procedures. Please note that in addition to Utilization Reviews, Mercy Health Plans' practices Case Management, and therefore may provide You with information about additional services that are available to You such as disease management programs, health education, pre-admission counseling and patient advocacy.

Initial Determinations

For initial determinations, the Plan will make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this Section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an admission, procedure or service, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification.

In the case of an Adverse Determination, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the Adverse Determination; and will provide written or electronic confirmation of the telephone notification to You and Your provider within one (1) working day of making the Adverse Determination.

Concurrent Review Determinations

For concurrent review determinations, the Plan will make the determination within one (1) working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, the Plan will notify by telephone the provider rendering the service within one (1) working day of making the certification.

In the case of an Adverse Determination, the Plan will notify by telephone the provider rendering the services within twenty-four (24) hours of making the Adverse Determination, and provide written or electronic notification to You and Your provider within one (1) working day of the telephone notification.

Retrospective Review Determinations

For retrospective review determinations, the Plan will make the determination within thirty (30) working days of receiving all necessary information. The Plan will provide notice in writing of Our determination to You within ten (10) working days of making the determination.

Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. The Plan will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination, to any party who received notice of the Adverse Determination, and who requests such information.

Reconsideration of an Adverse Determination

In a case involving an initial determination or a concurrent review determination, the Plan will give the provider rendering the service an opportunity to request, on Your behalf, a reconsideration of an Adverse Determination by the reviewer making the Adverse Determination.

The reconsideration will occur within one (1) working day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the Adverse Determination, or a clinical peer designated by the reviewer who made the Adverse Determination (if the reviewer who made the Adverse Determination is not available within one (1) working day).

If the reconsideration process does not resolve the difference of opinion, You or Your provider may appeal the Adverse Determination. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an Adverse Determination.

Lack of Information

The Plan will have written procedures to address failure or inability of a provider or an enrollee to provide all necessary Information for review. In cases where the provider or an enrollee will not release necessary information, the Plan may deny certification of an admission, procedure or service.

Complaint and Grievance Procedures

These procedures address all Complaints, Grievances, and appeals concerning operation of Mercy Health Plans except any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment. The Complaint procedure is more fully described in Section 8 (Complaints, Grievances and Appeals).

Section 10: General Provisions

Your Relationship with Us

In order to make choices about Your health care coverage and treatment, We believe that it is important for You to understand how We interact with You. We help finance and administer the benefit plan in which You are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to You decisions about whether Your benefit plan will cover or pay for the health care that You may receive. The plan pays for certain medical costs, which are more fully described in this Policy. The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.
- We do not decide what care You need or will receive. You and Your Physician make those decisions.

We may use individually identifiable information about You to share with You (and You alone) procedures, products or services that You may find valuable. We will use individually identifiable information about You as permitted or required by law, in Our operations and in Our research. We will use de-identified data for commercial purposes, including research.

Our Relationship with You

The relationship between You and the Plan is solely a contractual relationship between independent contractors. You are not Our agent or employee. Neither We nor any of Our employees are Your agents.

We do not provide health care services or supplies, nor do We practice medicine. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of Benefits under Your benefit plan.

You are solely responsible for all of the following:
- Enrollment changes (including the termination of Your coverage).
- The timely payment of the required premium to Us.

Your Relationship with Providers

The relationship between You and any provider is that of provider and patient;
- You are responsible for choosing Your own provider;
- You must decide if any provider treating You is right for You;
  This includes providers You choose and providers to whom You have been referred;
- You must decide with Your provider what care You should receive;
- Your provider is solely responsible for the quality of the services provided to You.

Administrative Services

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Our sole discretion. We are not required to give You prior notice of any such change, nor are We required to obtain Your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, We reserve the right, in Our sole discretion and without Your approval, to change, interpret, modify, withdraw or add Benefits, or terminate the Policy.

Any provision of the Policy that on its Effective Date is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy, unless it is made by an Amendment or Rider that has been signed by one of Our officers. All of the following conditions apply:

- Amendments to the Policy are effective thirty-one (31) days after We send a written notice to the Enrolling Individual.
- Riders are effective on the date We specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Assignment

This Policy and all the rights, responsibilities and benefit payments under it are personal to You. You may assign them to any Provider of Covered Service.

Case Management

Case Management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family, and the attending physician to determine appropriate treatment options that will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation, or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to You or Your Dependent. In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive You of Benefits under the Policy, nor will it create a right to Benefits. If the Enrolling Individual makes a clerical error (including, but not limited to, sending Us inaccurate information regarding Your enrollment for coverage or the termination of Your coverage under the Policy) We will not make retroactive adjustments beyond a 60-day time period.

Conformity with State Laws

If any provision(s) of this Policy conflicts with Arkansas law, then those provision(s) are automatically changed to conform to at least the minimum requirements of the law.

Commission or Omission

No Hospital, Physician or other Provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other Providers or services or their agent or employee; or (4) You.

Entire Policy/Changes

The Policy issued to You, Your application, Amendments and any applicable Riders constitute the entire Policy. No change in this Policy will be valid until approved by one of Our executive officers, and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Examination of Covered Persons

In the event of a question or dispute regarding Your right to Benefits, We may require that a Network Physician of Our choice examine You at Our expense.

Incentives to You

Sometimes We may offer coupons or other incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is Yours alone, but We recommend that You discuss participating in such programs with Your Physician. These incentives are not Benefits and do not alter or affect Your Benefits. Contact Us if You have any questions.

Incorporation by Reference

Unless otherwise stated herein, the Schedule of Coverage and Benefits, the schedule of rates and premiums, any riders, the application, and any amendments to any of the foregoing, form a part of this Policy as if fully incorporated herein.

Information and Records

At times, We may need additional information from You. You agree to furnish Us with all information and proofs that We may reasonably require regarding any matters pertaining to the Policy. If You do not provide this information when requested, We may delay or deny payment of Your Benefits.

By accepting Benefits under the Policy, You authorize and direct any person or institution that has provided services to You to furnish Us with all information or copies of records relating to the services provided to You. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents, whether or not they have signed the Subscriber's application form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning Health Care Services that are necessary to implement and administer the terms of the Policy for appropriate medical review, quality assessment, or as We are required to do by law or regulation. During and after the term of the Policy, Our related entities and We may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of Your medical records or billing statements, We recommend that You contact Your health care provider. Providers may charge You reasonable fees to cover their costs for providing records or completing requested forms.

If You request medical forms or records from Us, We also may charge You reasonable fees to cover costs for completing the forms or providing the records.

In some cases, We will designate other persons or entities to request records or information from or related to You, and to release those records as necessary. Our designees have the same rights to this information as We have.

You will give Us information reasonably necessary to maintain Your records on a current basis. Failure to provide such information may terminate this Policy. Our clerical errors or delays in keeping or reporting data relative to coverage will not terminate coverage which would otherwise be in force, nor continue coverage which would otherwise be terminated. Upon discovery of errors or delays, We will make whatever change is needed to assure that You have the coverage to which You are entitled to. No retroactive coverage or Premium changes will be made unless prior written approval is received from Us. Retroactive changes beyond sixty (60) days will not be approved unless We are at fault.

Interpretation of Eligibility and Benefits

We have sole discretion to do all of the following:

- Determine eligibility;
- Interpret Benefits under the Policy;
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this Policy and any Riders and Amendments;
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case shall not in any way be deemed to require Us to do so in other similar cases.

Legal Actions

You may not bring any action of law or in equity concerning a claims payment until sixty (60) days after written proof of claim for Benefit payment has been furnished to Us, in accordance with the requirements of the Policy. Any such action must be filed within three (3) years of the date a claim is required to be sent to Us.

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Covered Persons who are eligible for or enrolled in Medicare may NOT be covered under the Policy.

Misstatement of Age

If the age of the insured has been misstated, all amounts payable under this Policy shall be equal to the amount that the premium paid would have been purchased at the actual age when the policy was issued.

Notice

When We provide written notice regarding administration of the Policy to Your authorized representative, that notice is deemed notice to You and Your Enrolled Dependents.

Any notice required under this Policy will be sufficient if it is in writing, and mailed or delivered:

a) To You, when addressed to You at the address currently appearing on Our records; or
b) To Mercy Health Plans, when addressed to 14528 S Outer 40, Suite 300, Chesterfield, Missouri 63017-5743.

Policies, Identification Cards and Applications

We will furnish You with identification cards, copies of this Policy, and applications.

Reimbursement to Us

a) As a Covered Person, You agree to refund Us any benefit payment We made to You, or on Your behalf, for a claim paid or payable under Workers' Compensation or employers' liability law. Even if You fail to claim through a Workers' Compensation or employers' liability law, and You could have received payment through such a law if You had filed, reimbursement must still be made to Us. We have the right to credit payments of such claims against future claims in all cases.

b) We have the right to correct benefit payments paid in error. Hospitals, Physicians, other Providers and/or You have the responsibility to return any overpayment, including claims made involving fraud to Us. We have the responsibility to make additional payment if an underpayment is made.

Right of Reimbursement

In consideration of the coverage provided by this Certificate of Coverage, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;

- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us,
  - Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - Responding to requests for information about any accident or injuries,
  - Making court appearances, and
  - Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

Statements by Enrolling Individual or Subscriber

Except for fraudulent statements, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits, unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary.

Time Limit on Certain Defenses

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for charges incurred after the expiration of such three (3) year period.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by Workers' Compensation insurance.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
1. Ambulance Services- Emergency only	Medically Necessary ambulance service (either by a licensed ambulance service - ground or air ambulance) to the most appropriate Hospital where Emergency Care can be provided in the case of a Medical Condition and Medically Necessary transportation, however, use of air ambulance must be approved in advance or as soon as reasonably possible by the Plan. Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in emergency situations. See Section 12, T., for related exclusions.
2. Dental-Anesthesia and Facility Charges	Administration of general anesthesia and Hospital charges for dental care if: • The Covered Person is a child under the age of seven (7) who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or • The Covered Person is diagnosed with a serious mental or physical condition; or • The Covered Person has a significant behavioral problem as determined by the Plan. Limitations and Exclusions are described in Section 12, E. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits for dental anesthesia and related facility charges will be reduced by 50% of Eligible Expenses.
3. Diabetes Services	Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes. Coverage is provided for insulin infusion devices, insulin pumps, and associated supplies. Services for **diabetes self-management training**: Covered Health Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a licensed physician and a licensed health care professional must certify that the Covered Person successfully completed the training program. Coverage is limited to one(1) program during the entire time a Covered Person is Covered under this Certificate. A provider licensed, registered, and/or certified in the state to provide appropriate Health Care Services must provide diabetes self-management training program. Training is to be provided upon the initial diagnosis of diabetes, when there is a significant change in the Member's symptoms or when the Food and Drug Administration for the treatment of diabetes approve new techniques and treatments. **Prior Authorization Required** You must obtain Prior Authorization before receiving services for the following: ▪ Insulin pumps Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
4. Emergency Room Services	Emergency Room Services that are required to stabilize or initiate treatment in an Emergency. Emergency Room Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Room Services in Section 5 (How You Get Care).

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Physician charges may be applicable, if billed separately. See *Professional Fees for Surgical and Medical Services* below. Please remember that if You are admitted to a Hospital as a result of an Emergency, You must notify Us within two (2) working days or the same day of admission, or as soon as reasonably possible to receive authorization for continued services related to post-stabilization, as needed. If You don't notify Us, Benefits for the Hospital Inpatient Stay will be reduced to by 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services. Please refer to Hospital – Inpatient Stay below. If an Emergency Room admission results in a conversion to an Inpatient Stay or Observation Care, the Emergency room Copayment/Coinsurance charge will be waived when the hospital inpatient or observation admission for the same condition occurs within twenty-four (24) hours. The alternate higher level Copayment/Coinsurance will apply.
5. Hearing Screenings for Newborns	Newborn hearing screenings, necessary re-screening, audiological assessment and follow-up, and initial amplification.
6. Immunization – Routine Only	Routine immunizations as defined by the Plan. Coverage limitations may apply. Immunizations required for international travel are excluded. A list of routine immunizations can be obtained at **www.mercyhealthplans.com** or by calling Our Customer Contact Center at the number listed on Your ID card. There is no Copayment, Coinsurance or Deductible for routine immunizations. Applicable Copayments for office visit will apply. All other preventive health care services will be subject to Copayment, Coinsurance, Deductible, or dollar limit provisions.
7. Inpatient Hospital Services	Inpatient Hospital Services are available for: • Services and supplies received during the Inpatient stay. • Room and board in a Semi-private Room (a room with two or more beds), or • A private room only when medically necessary and approved in advance by the Plan. **Prior Authorization Required** Please remember that You must notify Us as follows: • For elective admissions; and • For Emergency admissions: within two (2) working days or the same day of admission, or as soon as is reasonably possible. Unless We pre-approve inpatient Hospital services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
8. Maternity Services	Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any related complications. Sonograms in uncomplicated pregnancies are limited to two per pregnancy. We will pay Benefits for an Inpatient Stay of: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean Section delivery. • 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Early discharge requires that both of the following requirements are met: • The discharge complies with the guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. • The mother and child are provided post-discharge care as determined by the attending physician. Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician; and includes parent education, training in breast or bottle-feeding, and appropriate testing of the mother and child. Copayments and Deductible requirements apply to normal newborn admissions and both the mother and newborn will incur separate inpatient Copayments/Deductibles as follows: • If the mother and newborn are discharged from the same hospital on the same day, applicable Copayments/Coinsurances and Deductible will apply separately for the mother and the newborn; however, the Deductible will be waived for the newborn; • If the mother and newborn are *not* discharged from the same hospital on the same day, both the mother and newborn will each incur applicable Copayments/Coinsurances and Deductibles for their inpatient hospital stay. The newborn's inpatient hospital Copayment/Coinsurance and Deductible will cover the dates of service *after* the mother's discharge, or dates of service at a different hospital. • If the newborn remains hospitalized after the mother's discharge date, an inpatient authorization is required for the dates of service after the mother's discharge date, and vice versa. See "Prior Authorization Required" below. **Note: The number of prenatal visits or change in Physician may effect Your Copayment/Coinsurance.** **<u>Prior Authorization Required</u>** Please remember that You must notify Us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. Unless We pre-approve any extended inpatient Hospital services beyond labor and delivery for either You or Your newborn, Your Network and Non-Network Benefits for the extended stay will be reduced by 50% of Eligible Benefits.
9. Newborn Child Coverage	Coverage for newborn children begins from the moment of birth. Benefits include coverage for illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, all other disorders of metabolism, and routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period. **<u>Prior Authorization Required</u>** We must be notified within ninety (90) days of birth, or Your next Premium due date, whichever is greater. If You don't notify Us, You will be responsible for paying 100% charges <u>incurred after the lesser of five (5) days, or the mother's discharge date.</u>
10. Observation Care	Observation Care are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	inpatient. Most observation services do not exceed one (1) day. Members may be admitted as Observation status to beds in the Emergency room, an observation unit, the intensive care unit, or a regular floor. If an Observation admission results in a conversion to an Inpatient Admission for the same condition within twenty (24) hours, the Observation Copayment will be waived. The alternate Copayment/Coinsurance will apply. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
11. Osteoporosis Services/Bone Mineral Density (BMD) Testing	Diagnosis, treatment, and appropriate management of osteoporosis for Covered Persons with a condition or medical history for which bone mass measurement is medically indicated. Coverage limitations may apply. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. **Prior Authorization Required** Unless We pre-approve services requiring Prior Authorization, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
12. Outpatient Diagnostic Services	Covered health services received on an outpatient basis at a Hospital or Alternate Facility for laboratory and medical diagnostic services. • Laboratory servies; • X-ray/imaging services; • Other diagnostic tests and therapeutic treatments (including cancer Chemotherapy or intravenous infusion therapy). Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on your ID card. Benefits under this Section include only the facility charge and the charge for required services, supplies and equipment. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
13. Outpatient Surgery/Hospital Procedures	Covered surgical services and other medical care received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this Section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below, and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment. **Surgical Implants**, whether inserted in the inpatient, outpatient, or office setting, including pacemakers,

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	stents, and other implantable devices or treatments. Copayment is consistent with type of service required. Implants for cosmetic or psychological reasons are excluded, see Section 12, M. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on your ID card. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
14. Physician's Office Services	Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury; • Preventive medical care; • Well-baby and well-child care including children's preventive health care services for children from birth through eighteen (18) years of age; • Routine physical examinations.
15. PKU/Medical Foods and Low Protein Modified Food Products for Metabolic Disorders	Benefits are provided for Medical Foods and Low Protein Modified Food Products for Metabolic Disorders if the following are met: • The Medical Food or Low Protein Modified Food Products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; • The products are administered under the direction of a licensed physician; and • The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the $2,400 per year per person. See Section 12, K. for limitations and exclusions related to this benefit.
16. Preventive Health & Wellness Care	Preventive Health Screenings are for non-symptomatic persons in accordance with the American Cancer Society guidelines and Mercy Health Plans' preventive health guidelines. Preventive Health Screenings include one (1) routine test of each of the following every [Calendar] [Plan] Year, unless otherwise indicated: • Cholesterol Tests • Colon Screening: – Colonoscopy – one (1) routine screening every ten (10) years – Double-contrast Barium Enema – one (1) routine screening every five (5) years – Flexible Sigmoidoscopy – one (1) routine screening every five (5) years – Fecal Occult Blood Test • Mammography • Pap Test • Pelvic Exam • Prostate Exam • PSA test [Preventive Health Screenings are covered in-Network with no Deductible. Deductible and Coinsurances will apply to services received from a Non-Network Provider.]

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
17. Professional Fees for Surgical and Medical Services	Professional fees for surgical procedures and other medical care provided in an outpatient facility. You may incur a separate copayment/coinsurance in addition to the outpatient facility charge. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.
18. Reconstructive Procedures	Services for reconstructive procedures, when a physical impairment exists, and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. See Section 12, M. for related limitations and exclusions. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast disease, and reconstruction of the Non-affected breast to achieve symmetry. Reconstructive surgery for breast reconstruction and the receipt of a related prosthetic devices may follow a mastectomy at any time. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at the telephone number on Your ID card for more information about Benefits for mastectomy-related services. **Prior Authorization Required** You must notify Us before receiving services. When You notify Us, We can verify that the service is a reconstructive procedure, rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. Unless We pre-approve a Covered reconstructive Service, Network and Non-Network Benefits for reconstructive procedures will be reduced by 100% of Eligible Expenses.
19. Rehabilitation Services	***Outpatient Rehabilitation Therapy:*** Short-term outpatient rehabilitation services for: • Physical Therapy; • Occupational Therapy; • Speech Therapy; • Pulmonary Rehabilitation Therapy; • Cardiac Rehabilitation Therapy. Also includes covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for treatment for loss or impairment of speech or hearing. "Short-term" means rehabilitation services that are expected to result in significant physical improvement in Your condition within two (2) months of the start of treatment. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Home rehabilitation services are limited to the Homebound patient and considered separately under the home health Benefit.

	Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**
	Please note that We will pay Benefits for Speech Therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Rehabilitation therapy services that are considered maintenance, developmental or educational in nature are not covered Benefits. Exclusions are described in Section 12, R. Any combination of Network and Non-Network Benefits is limited as according to Your Schedule of Coverage and Benefits. ***Inpatient Rehabilitation Services:*** Medically Necessary services for an Inpatient Stay in an Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-Private Room Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or non-elective inpatient rehabilitation admission. Unless We pre-approve inpatient rehabilitation services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For emergency admission, You must notify Us within two (2) working days or as soon as reasonably possible.
20. Skilled Nursing Facility (SNF)	Medically Necessary services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay; • Room and board in a Semi-private Room. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or Non-elective admission. Unless we pre-approve SNF services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For emergency admissions, You must notify Us with two (2) working days or as soon as reasonably possible.
21. Urgent Care Center Services	Covered Health Services received at an Urgent Care Center. If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this Section.

Section 12: Exclusions – Things We Don't Cover

This Section contains information about Medical services that are not covered. We call these Exclusions. It's important for You to know what services and supplies are not covered under the Policy.

We do not pay Benefits for exclusions or any related complications.

We will not pay Benefits for any of the services, treatments, items or supplies described in this Section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for Your condition.

The services, treatments, items or supplies listed in this Section are not Covered Health Services, except as may be specifically provided for in Section 11 (Covered Benefits) or through a Rider to the Policy.

Category	Description
A. Allergy	We do not cover any allergy related injections and serum, treatment, or testing.
B. Alternative Treatments	We do not cover alternative treatments, including but not limited to: 1. Acupressure and Acupuncture. 2. Aromatherapy. 3. Hypnotism. 4. Massage Therapy. 5. Rolfing. 6. Herbal remedies. 7. Ayurvedic therapies. 8. Reflexology. 9. Biofeedback and neurofeedback therapy. 10. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
C. Chiropractic	Under no circumstances will coverage be provided for: 1. Services beyond the scope of the Network Chiropractor's license to practice chiropractic care. 2. Services in excess of the chiropractic visit limitations indicated in Your Schedule of Coverage and Benefits. 3. Preventive care services. 4. Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders. 5. Services that are not considered Medically Necessary and/or clinically appropriate.
D. Comfort or Convenience	1. Television. 2. Telephone. 3. Beauty/Barber service. 4. Guest service. 5. Automated travel devices (motor scooters). 6. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include: - Air conditioners - Air purifiers and filters - Batteries and battery chargers - Dehumidifiers and Humidifiers - Electrostatic machines - Lights/lighting - Portable room heaters, grab bars, etc. - Vaporizers - Tanning booths - Bath chairs - Breast pumps, unless newborn in NICU - Exercise equipment - Raised or regular toilet seats - Whirlpools, saunas, and hot tubs

Category	Description
	7. Devices and computers to assist in communication and speech. Augmentative communication devices, including, but not limited to, computer assisted speech devices, speech teaching machines, telephones, TDD equipment, Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, Non-digital voice systems, such as the Electro-Larynx, after post-radical neck or other invasive surgery that interferes with laryngeal function. 8. Personal hygiene items and hygienic items, including, but not limited to, shower chairs, commodes (unless the individual is confined to room or bed), incontinence pads, bed baths, etc. 9. Devices that are primarily non-medical in nature or used primarily for comfort, including, but not limited to: - Bed boards - Elevators - Foam pads - Heating pads - Beds other than standard single hospital beds - Overbed tables - Carafes - Emesis basins - Maternity belts - Bathtub seats - Standing tables 10. Chair lifts, bathtub lifts, bed lifter, and other similar devices. 11. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.
E. Dental	1. Dental care, including Accidental Dental, except as described in Section 12 (Covered Benefits) under the heading, "Dental – Anesthesia and Facility Charges". 2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following: – Extraction, restoration and replacement of teeth; – Medical or surgical treatments of dental conditions; – Services to improve dental clinical outcomes; – Services for overbite or underbite; – Services related to surgery for cutting through the lower or upper jaw bone; – Maxillary and mandibulary osteotomies 3. Dental implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded. 4. Dental braces and occlusal splints, even if associated with Accidental Dental Services. 5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: – Transplant preparation; – Initiation of immunosuppressives; – The direct treatment of acute traumatic Injury; – The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment); – Cleft palate; – Covered Persons with conditions outlined in Section 11 (Covered Benefits) under Dental – Anesthesia and Facility Charges; 6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly. 7. Orthodontic services. 8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. 9. Upper and lower jawbone surgery except as required for direct treatment of acute

Category	Description
	traumatic injury or cancer. 10. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint syndrome, except as a treatment of obstructive sleep apnea.
F. Drugs	1. Prescription drug products for outpatient use (including self-injectables) that are filled by a prescription order or refill. 2. Non-injectable medications given in a Physician's office except as required in an Emergency. 3. Over the counter drugs and treatments. 4. Charges for supplies for use beyond the first twenty-four (24) hours following discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any prescription drugs intended primarily for home use. 5. Injectables/Infusions provided in a Physician's office, infusion center or through home health.
G. Experimental, Investigational or Unproven Services	1. Experimental, Investigational or Unproven Services are excluded including routine patient care costs for phase II, III or IV of clinical trials undertaken for the purpose of the prevention, early detection and treatment of cancer. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
H. Foot Care	1. Routine foot care (including the cutting or removal of corns and calluses). 2. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection. 3. Hygienic and preventive maintenance foot care. Examples include the following: – Cleaning and soaking the feet; – Applying skin creams in order to maintain skin tone; and – Other services that are performed when there is not a localized illness, Injury or symptom involving the foot. 4. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet, unless otherwise noted in this document. 5. Treatment of subluxation of the foot. 6. Shoe orthotics, orthopedic shoes and other supportive appliances for feet**.**
I. Medical Supplies and Appliances	1. Devices used specifically as safety items or to affect performance in sports-related activities. 2. Prescribed or Non-prescribed medical supplies and disposable supplies. Examples include: – Elastic stockings – Ace bandages – Gauze and dressings – Disposable sheets and bags – Fabric supports – Surgical face masks – Incontinent pads, including diapers – Irrigating kits – Pressure leotards – Surgical leggings and support hose Exceptions include diabetic supplies. 3. All orthotic and prosthetic devices/equipment except for breast prosthetics following a mastectomy. 4. Tubings and masks. 5. Devices and equipment that are not normally appropriate outside of a hospital (or other provider) setting, including, but not limited to:

Category	Description
	– Home monitoring devices and supplies, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders) – Home prenatal monitoring and associated nursing support 6. Lift Seats. 7. DME is not covered except for Diabetes Services related equipment as described in Section 11 (Covered Benefits).
J. Mental Health/Substance Abuse	1. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders. 2. Psychosurgery. 3. Vagus nerve stimulation (VNS) for depression. 4. Residential treatment services.
K. Nutrition	1. Megavitamin and nutrition based therapy (for any purpose). 2. Vitamins (other than those prenatal vitamins prescribed for a Member who is then pregnant). 3. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except for treatment of Diabetes only. 4. Medical foods and other nutritional and electrolyte supplements taken orally, parenterally or enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any inherited disease of amino or organic acids. 5. Nutritional Supplements when tube feeding is the sole source of nutrition is also excluded.
L. Personal	1. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: a. Required solely for purposes of career, education, sports or camp, travel, recreation, employment, insurance, marriage or adoption. b. Related to judicial or administrative proceedings or orders. c. Conducted for purposes of medical research. d. Required to obtain or maintain a license of any type. 2. Custodial Care. See Section 13 (Definitions of Terms). *3.* Domiciliary care or any nursing care on full-time basis in Your home. 4. Private Duty Nursing. See Section 13 (Definitions of Terms). 5. Respite care. 6. Rest cures. 7. Medical and surgical treatment of excessive sweating (hyperhidrosis). 8. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. 9. Oral appliances for snoring. 10. Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony. 11. Work place evaluations and work hardening treatment. 12. Home Health Care Services. 13. Hospice/Pallative Care. 14. Tobacco Cessation education program and products. 15. Dialysis.
M. Physical Appearance	1. Cosmetic Procedures. See the definition in Section 13 (Definitions of Terms). Examples include: – Pharmacological regimens, nutritional procedures or treatments. – Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). – Skin abrasion procedures performed as a treatment for acne. – Liposuction. – Hair transplant for baldness. – Correction of asymmetric breasts or abnormal nipple-areolar complexes and

Category	Description
	protruding ears. – All other cosmetic services **except** if medically necessary to: i. Repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan; ii. Restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Member under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of normal human variation; or iii. Reconstructive breast surgery performed post-mastectomy. 2. Replacement of an existing breast implant, if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 11 (Covered Benefits). 3. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. 4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. 5. Wigs, regardless of the reason for the hair loss except as otherwise provided by law. 6. Treatment of benign gynecomastia (abnormal breast enlargement in males). 7. Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office visits associated with any weight loss program. 8. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded. 9. Sex transformation operations. 10. Breast Reduction Surgery (Reduction Mammoplasty).
N. Pre-Existing Conditions	Benefits for the treatment of a Preexisting Condition are excluded until the date You have been covered under this Policy for a period of twelve (12) months, except this waiting period will not apply to: 1. A child who is placed in a Member's physical custody for purposes of adoption if the petition for adoption is filed within sixty (60) days of placement of such child; or 2. A newborn if an application for coverage is filed within ninety (90) days of the birth of the child. 3. A person who has had creditable coverage for eighteen (18) months without a break of sixty-three (63) days or more.
O. Providers	1. Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. 2. Services performed by a provider with Your same legal residence. 3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who *is* an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider: a. Has not been actively involved in Your medical care prior to ordering the service, or b. Is not actively involved in Your medical care after the service is received. This exclusion does not apply to mammography testing. 4. Charges Incurred for broken appointments with a Participating Physician.

Category	Description
P. Reproduction	1. Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, in-vitro fertilization, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy. 2. Surrogate parenting. 3. Voluntary sterilization or the reversal of voluntary sterilization. 4. Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother. 5. Contraceptive supplies and services 6. Fetal reduction surgery. 7. Health services associated with the use of Non-surgical or drug induced Pregnancy termination. 8. Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function, unless otherwise covered in this Policy.
Q. Services Provided under Another Plan	1. Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. 2. Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by Workers' Compensation or similar law. If coverage under Workers' Compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under Workers' Compensation or similar legislation, if that coverage had been elected. 3. Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage, and facilities are reasonably available to You. 4. Health services while on active military duty. Upon notifying Mercy Health Plans of entry into military service, any pro-rata unearned premiums shall be refunded. 5. Injury or Illness incurred while incarcerated in any local, municipal, state or Federal facility.
R. Therapies/Psychological Testing	1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin (unless otherwise covered under this Policy, or by law). Speech Therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Cognitive therapy. 3. Psychological testing for any reason. 4. Neuropsychological Testing for any reason. 5. All Educational Services, including treatment of learning disorders and acquired cognitive deficits. 6. Water exercise and other exercises not under the supervision of a physical therapist. 7. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 8. Therapy for conditions such as developmental delay, ADHD, and autism.

Category	Description
S. Transplants	1. Health services for organ and tissue transplants. 2. Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. 3. Health services for transplants involving mechanical or animal organs.
T. Travel	1. Health services provided in a foreign country, unless required as Emergency Care Services. 2. Travel or transportation expenses, even though prescribed by a Physician, except for medically necessary ambulance services. 3. Air ambulance services outside the continental United States for any reason.
U. Vision and Hearing	1. Purchase cost of eye glasses, contact lenses (except for eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a $300.00 dollar benefit per lifetime), or hearing aids. 2. Fitting charge for hearing aids, eye glasses or contact lenses. 3. Eye exercise therapy (orthoptics or pleoptic training). 4. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery. 5. Routine eye examination by an ophthalmologist or optometrist for the correction of refractive errors.
V. General/ Administrative	1. Health services and supplies that are not included in Section 11 (Covered Benefits), or that do not meet the definition of a Covered Health Service - see the definition in Section 13 (Definitions of Terms). 2. Health services received as a result of any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country. 3. Health services received after the date Your coverage under the Policy ends, including health services for medical conditions arising before the date Your coverage under the Policy ends. 4. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. 5. Charges in excess of the Usual and Customary Rate (UCR) or in excess of any specified limitation. 6. Complications of Health Care Services that are not Covered Health Services. 7. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan. 8. Autopsies (post-mortem exams).

Section 13: Definitions of Terms

Adverse Determination A decision by Mercy Health Plans that an admission, availability of care or continued stay has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness leading to a decision that coverage for the requested service is denied, reduced or terminated.

Alternate Facility A health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

Amendment Any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible/Deductible If applicable, the amount You must pay for Covered Health Services in a [Calendar] [Plan] Year before We will begin paying for Benefits in that [Calendar] [Plan] Year. Deductible amounts are separate from and not reduced by Copayments. Deductible and Copayments are in addition to any coinsurance You pay.

Benefits Your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this Policy of Coverage and any attached Riders and Amendments.

Calendar Year January 1 through December 31 of the same year.

Cardiac Rehabilitation A comprehensive program to rehabilitate the heart.

Case Management A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health Conditions. Case Management may include:

1. Assessment of Your individual benefit needs;
2. Formulation and modification of a comprehensive benefit plan of action;
3. Coordination of Benefits;
4. Evaluation of the effectiveness of the plan of action; and
5. Negotiation of extra-contractual services, if necessary.

Certificate of Coverage This document including all Riders, Amendments and Schedule of Coverage.

Chemotherapy Treatment of disease by FDA-approved antineoplastic agents.

Coinsurance Coinsurance is the percentage of Our allowance that You must pay for Your care. You may also be responsible for other costs for Your care such as a Deductible. See Section 6 (Your Cost for Covered Services).

Congenital Anomaly A physical developmental defect that is present at birth, and is identified within the first twelve (12) months of birth.

Continuous Creditable Coverage Health care coverage under any of the types of plans listed below, during which there was a break in coverage of no more than sixty-three (63) consecutive days, and provided there were eighteen (18) continuous months of eligible coverage:

- A group or individual insured health plan.
- Self-funded health plan coverage permitted by ERISA.
- Medicare.

- Medicaid.
- Medical and dental care for Members and certain former Members of the uniformed services, and for their Dependents.
- A medical care program of the Indian Health Services Program or a tribal organization.
- A state health Benefits risk pool.
- The Federal Employees Health Benefits Program.
- Any public health benefit program provided by a state, county, or other public subdivision of a state.
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Copayment

A Copayment is a fixed amount of money You pay when You receive covered services. See Section 6 (Your Cost for Covered Services).

Cosmetic Procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Us.

Covered Health Service(s)/Covered Services

A Covered Health Service is a Health Care Service or supply described in Section 12 (Covered Benefits) as a Covered Health Service. A Covered Health Service is a Health Care Service or supply which is not excluded under Section 12 (Exclusions) and meets the following conditions:

1) Prescribed by a Physician for the therapeutic treatment of Injury, Illness or Pregnancy;
2) Deemed Medically Necessary and appropriate in type, level, setting, and length of service; and if required by the Plan, is authorized on a prospective and timely basis by the Plan's Medical Director.
3) Rendered in accordance with generally accepted medical practice and professionally recognized standards;
4) Provided on or after the Effective Date and before Your coverage terminates in accordance with Section 4 (When Coverage Ends) and at a time when You met all applicable requirements for eligibility set forth in Section 3 (When Coverage Begins).
5) Services that are specifically included and not excluded or limited, or not specifically excluded by the Plan.

Covered Person

Either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "You" and "Your" throughout this Policy are references to a Covered Person.

Custodial Care

Services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent

The Subscriber's legal Spouse or an unmarried Dependent child of the Subscriber. The term child includes any of the following:

- A natural child;
- A stepchild;
- A legally adopted child;
- A child placed for adoption;
- A child for whom permanent legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse.

To be eligible for coverage under the Policy, a Dependent’s domicile and his/her primary residence must be in Arkansas. The definition of Dependent is subject to these conditions and limitations:

- A Dependent includes any unmarried dependent child under 19 years of age;
- A Dependent includes an unmarried dependent child who is 19 years of age or older to [23 – 25] years of age, only if You furnish evidence upon Our request, satisfactory to Us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Individual is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility

A Hospital that We name as a Designated Facility. A Designated Facility has entered into an agreement with Us, or with an organization contracting on Our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within Our geographic area.

Durable Medical Equipment (DME)

Medical equipment that is all of the following:

- Can withstand repeated use;
- Is not disposable;
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Is generally not useful to individuals in the absence of a Sickness, Injury or their symptoms;
- Is appropriate for use in the home.

Eligible Expenses

The amount We will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

Eligible Expenses are determined solely in accordance with Our reimbursement policy guidelines. We develop Our reimbursement policy guidelines, in Our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications.
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that We accept.

Eligible Person

An Eligible Person is a Subscriber or Dependent that was covered under the [group] Policy this conversion Policy replaces on the date of termination of such group Policy. An Eligible Person's domicile and his/her primary residence must be located within Arkansas. In addition, an Eligible person is not/cannot be covered by Medicare, or by another health insurance policy, whether individual or group, or by similar benefits provided by any state or federal law.

Emergency

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but will not be limited to, any of the following:

- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;

- Inadequately controlled pain;
- With respect to a pregnant woman who is having contractions, either of the following:
  - Inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery;
  - The transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Care/Emergency Room Services Health Care Services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent A Dependent who is properly enrolled under the Policy.

Enrolling Individual The individual to whom the Policy is issued.

Experimental or Investigational Services Medical, surgical, diagnostic, psychiatric, substance abuse or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

External Independent Reviewer A clinical peer with no direct financial interest in connection with the Grievance/appeal in question and who has not been informed of the specific identity of the Enrollee.

External Review A process, independent of all affected parties, to determine if a Health Care Service is medically necessary or Experimental/Investigational.

Full-Time Student An unmarried dependent child who is between the ages of 19 – 23 that meets all the following conditions:

- The child must not be regularly employed on a full-time basis;
- The child must be primarily dependent upon the Subscriber for support and maintenance;
- The child must be attending, fulltime, a recognized course of study or training at one of the following:
  - An accredited high school;
  - An accredited college or university;
  - A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student on the date You graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If You do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Grievance A written Complaint submitted by or on behalf of a Member regarding the a) availability, delivery or quality of Health Care Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; b) claims payment, handling or reimbursement for Health Care Services; or c) matters pertaining to the contractual relationship between a Member and the Company.

Health Care Service(s)	Those health services provided for cosmetic or other non-medical purposes, or for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.
Homebound	Homebound means an individual who is confined to the home as a result of their physical or mental condition and that leaving home is a major effort and normally requires assistance. Leaving home is done to receive medical care or for short, infrequent non-medical reasons such as a trip to the grocery store, beauty parlor or barbershop, or to attend religious services.
Hospital	A legally constituted institution, having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facilities are operated as a separate institution by a hospital.
Implant(s)	That which is implanted such as a piece of tissue, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purpose. Examples of such Implants include stents, artificial joints, shunts, grafts pins, plates, screws, anchors and radioactive seeds.
Infertility	The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. (Sexual intercourse means the sexual union between a male and female). Infertility does not include individuals unable to conceive post sterilization.
Initial Enrollment Period	The initial period of time, as We agree with the Enrolling Individual, during which Eligible Persons may enroll themselves and their Dependents under the Policy.
Injury	Bodily damage other than Sickness, including all related conditions and recurrent symptoms.
Inpatient Rehabilitation Facility	A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.
Inpatient Stay	An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.
Low Protein Modified Food Products	Food products specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.
Maximum Policy Benefit	The maximum amount that We will pay for Benefits during the entire period of time that You are enrolled under the Policy issued to the Enrolling Individual. The Maximum Policy Benefit includes any amount that We have paid for Benefits under a former Policy issued to the Enrolling Individual that is replaced by the current Policy, as well as any amount that We may pay under a later Policy that replaces the Enrolling Individual's current Policy. When the Maximum Policy Benefit applies, it is described in Section 6 (Your Cost for Covered Services).
Medical Foods	Products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.
Medically Necessary	Health Care Services that are ordered by a Health Provider, without which there would be significant risk of a serious deterioration and/or a significant impairment that, if not treated, could seriously affect one's ability to function within his or her normal environment. Although some Health Care Services are medically acceptable, they may not be medically necessary. Health Care Services need to be (1) medically appropriate and necessary to meet the basic health

needs of the Member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; (4) consistent with the diagnosis of the conditions; and (5) of demonstrated medical value. Medically Necessary does not include care that is provided primarily for the convenience of the Member or a Health Provider, or care that is rendered more frequently than that accepted as medically appropriate by the medical profession.

Medicare Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Member A Member means any Subscriber or Dependent.

Mental Illness Those Conditions classified as mental disorders in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, except mental retardation

Network Benefits Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network provider in the provider's office or at a Network or Non-Network facility.

Network/Network Provider When used to describe a provider of Health Care Services, this means a provider that has a participation agreement in effect with Us or with Our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of Our products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement, and a Non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

Neuropsychological Testing Neuropsychological Testing is a quantitative, comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders.

Non-Network Benefits Benefits for Covered Health Services that are provided by a Non-Network Physician or other Non-Network provider.

Observation Care Care in the Hospital to monitor evaluate or stabilize a patient in order to determine the need for further treatment or an inpatient admission. Such Care is not considered Inpatient Care, even though the patient may be confined to a Hospital bed.

Occupational Therapy Treatment of a physically or mentally disabled person through constructive activities designed to restore the ability to accomplish satisfactorily the ordinary activities of daily living. Activities of daily living include feeding, dressing, bathing and other types of self-care.

Out-of-Pocket Maximum If applicable, the maximum amount of Coinsurance You pay every [Calendar] [Plan] Year. If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that [Calendar] [Plan] Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that [Calendar] [Plan] Year. See Section 6 (Your Cost for Covered Services).

Physical Therapy Treatment by physical means including hydrotherapy, heat, physical agents, and biomechanical and neurophysiological principles and devices that relieve pain or restore maximum bodily function. Physical Therapy does not include Cardiac Rehabilitation, Pulmonary Rehabilitation or Manipulation/Adjustment.

Physician Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that We describe a provider as a Physician does not mean that Benefits for services from that provider are available to You under the Policy.

[Plan Year] [Means the period of twelve (12) months commencing on the Effective Date of this Agreement and each twelve (12) month period thereafter (or other periods as indicated in the Individual Enrollment Agreement), unless otherwise terminated as provided herein.]

Policy This document including all riders, Amendments and Schedule of Coverage.

Policy Charge The sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy Includes all of the following:

- Prenatal care;
- Postnatal care;
- Childbirth;
- Any complications associated with Pregnancy, i.e., conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest period during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Premium The periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Prior Authorization Precertification review by the Plan, before services and treatment are rendered, to determine if the service meets the criteria as a Covered Health Service.

Preventive Health Screening(s) Routine tests performed on a healthy individual who has no signs or symptoms of disease, or history of the disease being screened. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient or a patient previously diagnosed with the disease being screened are classified as diagnostic tests. Diagnostic tests will incur Deductibles and/or Copayments/Coinsurances consistent with the services received.

Private Duty Nursing Private Duty Nursing is defined as one-on-one care provided on an individual basis either in an institution or in a patient's home. Private duty skilled nursing care can be considered custodial after Non-professional personnel repetitively performs the care, making continuous attention by a health professional no longer necessary, and is therefore not a covered benefit.

Pulmonary Rehabilitation A comprehensive program to manage patients with substantial chronic lung disease. Includes diagnostic testing, monitored dynamic exercise and education under the direct supervision of a qualified Physician.

Rider Any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-Private Room A room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Health Service, the difference in cost between a Semi-Private Room and a private room is a

Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.

Sickness Physical illness, disease or Pregnancy. The term Sickness as used in this Policy does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal Care, Custodial Care, ambulatory Care, part-time Care, or Care for Mental Illness and Substance Abuse, pulmonary tuberculosis or venereal disease.

Speech Therapy Treatment for loss or impairment of speech or hearing, including communicative disorders resulting from genetic defects, birth defects, injury, illness, disease, developmental disabilities or delays or other causes, whether of organic or nonorganic etiology and whether or not the person suffering from that loss or impairment had the capacity for speech, language or hearing before the loss or impairment occurred.

Subscriber An Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued.

The Plan The Plan refers to Mercy Health Plans.

Unproven Services Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a Individual of patients who receive standard therapy.
- The comparison Individual must be nearly identical to the study treatment Individual.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Urgent Care Center A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of Your health, within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Us/We/Our Us/We/Our refers to Mercy Health Plans.

Usual and Customary Rate (UCR) Charges for Covered Health Services which do not exceed the fees and prices generally approved for cases of comparable nature and severity at the time and place when such Covered Services are rendered or received. In determining the Usual and Customary Rate (UCR), the following guidelines shall be taken into consideration:

a) The usual fee which the individual health professional most frequently charges for a service or supply;
b) The prevailing rate of fees charged for identical or similar services in the same geographical area by health professionals of similar training and experience;
c) Unusual circumstances or complications that require additional time, skill and experience in connection with the provided service or supply;
d) The frequency of the determination of the usual and customary fee;
e) A general description of the methodology used to determine usual and customary fees;
f) The percentile that determines the maximum benefit the Plan will pay for any Accidental Injury dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then making the benefit by selecting a percentile of those fees.

Utilization Review	A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of Health Care Services, procedures or settings. Utilization Review may include Ambulatory Review, Prospective Review, second opinion, Certification, Concurrent Review, Case Management, Discharge Planning or Retrospective Review, but will not include elective requests for clarification of Coverage.
You/Your	You/Your refers to the Subscriber and each Enrolled Dependent.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MHP, Inc. by and on behalf of its wholly-owned subsidiaries, including Mercy Health Plans of Missouri, Inc., Mercy Health Plans, and Premier Benefits, Inc. (Collectively referred to as "the Plan"), respects the privacy of its Members and former Members and protects the security and confidentiality of their nonpublic personal information. We have instituted internal policies to: insure the security and confidentiality of Your personal and financial healthcare information; protect against any anticipated threats of hazards to the security or integrity of such records; and protect against unauthorized access to or use of information which could result in substantial harm or inconvenience to You. We are required by law to provide You with this Notice of Our legal duties and privacy practices. This Notice explains Your rights, Our legal duties, and Our privacy practices. To fulfill Our responsibilities to You, the Plan may use and disclose Your protected health information for treatment, payment, and healthcare operations, or when We are otherwise required or permitted to do so by law. Below is further detail explaining these situations.

TREATMENT
We may use and disclose protected health information with Your healthcare providers (physicians, pharmacies, hospitals and others) to assist in the diagnosis and treatment of Your injury or illness. For example, We may disclose Your protected health information to suggest treatment alternatives.

PAYMENT
We may use and disclose protected health information to pay for Your covered health expenses. For example, We may use protected health information to process claims. We may also ask a healthcare provider for details about Your treatment so that We may pay the claim for Your care.

HEALTHCARE OPERATIONS
We may use and disclose protected health information for Our healthcare operations. For example, We may use or disclose protected health information to perform quality assessment activities or provide You with case management services.

BUSINESS ASSOCIATES
We may, at times, need to use the services of other companies in lieu of Our own staff, such as outsourcing data entry services, or, as part of Our routine business, We may require that outside entities, such as auditors perform operations that require access to Our healthcare information. In order for Us to share confidential information with these organizations, We must enter into agreements that require them to comply with the privacy regulations of the Plan.

YOU OR YOUR PERSONAL REPRESENTATIVE
We must disclose Your health information to You as described in the Patient Rights Section below. If You have a legally-assigned personal representative or are an un-emancipated minor, We will release the information to Your personal representative or parent(s) as required by law.

FAMILY/FRIENDS
We may disclose Your health information to a family member or friend to the extent necessary to help with Your healthcare or with payment for Your healthcare, if You agree that We may do so. If You wish to designate a person(s) to whom We may discuss Your healthcare, You may submit a request to the address listed below. If You are physically or mentally unable to participate in decisions regarding Your healthcare, We may need to communicate with a family member; however, only to the extent necessary to insure that You receive appropriate healthcare treatment.

PERMITTED OR REQUIRED BY LAW
We must disclose protected health information about You when required to do so by law. Information about You may be used or disclosed to regulatory agencies, such as Medicare and Medicaid; for administrative or judicial hearings; public health authorities; or law enforcement officials, such as to comply with a court order or subpoena.

MEMBER AUTHORIZATION
Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding protected health information that the Plan maintains about You. If You wish to exercise any of these rights, You may submit Your request in writing.

- Right to Access Your Protected Health Information. You have the right to inspect and/or obtain a copy of individual protected health information that We maintain about You. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance.

- Right to Amend Your Protected Health Information. You have the right to request an amendment of individual protected health information that We maintain about You. All requests must be in writing and must include the reason for the change.

- Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of disclosures of individual protected health information made by the Plan on or after the compliance date of April 14, 2003. All requests must be in writing and must state the period of time for which You want the accounting. We may charge for providing the accounting, but We will tell You the cost in advance.

- Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that the Plan restrict the use and disclosure of Your protected health information for treatment, payment, or healthcare operations. The Plan is not required to agree to the requested restriction; however, if the Plan does agree to the restriction, it must comply with Your request, unless the information is needed for an emergency.

- Right to Receive Confidential Communications. You have the right to request to receive communication of protected health information from the Plan through an alternative procedure (other than the standard means of communicating protected health information). All requests must be in writing and are subject to technical reasonability for the Plan.

- Right to a Paper Copy of This Notice. You have the right at any time to receive a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.

CHANGES
The Plan reserves the right to change the terms of this Notice at any time, effective for protected health information that We already have about You as well as any information that We receive in the future. We are required by law to comply with whatever Notice is currently in effect. We will communicate changes to Our Notice through subscriber newsletters, direct mail and/or Our Internet website (www.mercyhealthplans.com).

COMPLAINTS
If You believe Your privacy rights have been violated, You have the right to file a complaint with the Plan and/or with the Federal Government. Complaints to the Plan may be directed to the appropriate Customer Contact Center listed at the end of this Notice or by calling the Customer Contact Center number listed on the back of Your ID card. You may also file a complaint anonymously by calling the Plan's Fraud and Abuse Hotline at 1-877-349-5997. Complaints to the government may be sent to: Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.

CONTACT THE PLAN
If You want more information about this Notice, how to exercise Your rights, or how to file a complaint, please direct Your correspondence to the appropriate Customer Contact Center listed at the end of this Notice or call the Customer Contact Center phone number listed on the back of Your ID card. You can also contact Us through Our Internet website: www.mercyhealthplans.com

Mercy Health Plans
ATTN: Customer Contact Center
14528 S Outer 40, Suite 300,
Chesterfield, MO 63017-5743

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for Your policy, contract or any portion of it that is not guaranteed by the insurer, or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverage, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act, or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);

- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a non-affiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance Benefits, $300,000 in present value of annuity Benefits, or $300,000 in life insurance death Benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity Benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those Benefits could be provided out of the assets of the impaired or insolvent insurer.

SCHEDULE OF COVERAGE AND BENEFITS
for
[NAME]
Effective Date of Coverage [MM/DD/YYYY]

With Mercy Health Plans' conversion Policy, You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network provider. You must show Your identification card (ID card) every time You request health care services from a Network provider. If You do not show Your ID card, Network providers have no way of knowing that You are enrolled under a Mercy Health Plans' Policy. As a result, they may bill You for the entire cost of the services You receive.

Please refer to Your Policy for a complete description of Your Benefits. In some cases, You must notify Us before receiving services.

PAYMENT INFORMATION	AMOUNT	
	NETWORK	NON-NETWORK
MEDICAL SERVICES **Annual Deductible**	[$500 - $2,500] per Covered Person per Calendar Year, not to exceed $3,000 for all Covered Persons in a family.	[$1,000 - $5,000] per Covered Person per Calendar Year, not to exceed $6,000 for all Covered Persons in a family.
Out-of-Pocket Maximum *Coinsurance is the amount You pay after You meet Your Deductible. All Coinsurances apply towards Your Out-of-Pocket Maximum, except those related to Covered Health Service contained in an optional Rider.* **Out-of-Pocket Maximum does not include the Annual Deductible.**	**Network and Non-Network** [$1,000 after Deductible per individual per Calendar Year, not to exceed $3,000 for all Covered Persons in a family.] [No Out-of-Pocket Maximum]	**Non-Network** No Out-of-Pocket Maximum
Maximum Policy Benefit	**Network and Non-Network Combined** $250,000 per Covered Person	

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
1. Ambulance Services - Emergency Only • Ground Transportation • Air Transportation ✸	*Ground Transportation:* 20% Coinsurance after Deductible *Air Transportation:* 45% Coinsurance after Deductible per transport	*Ground Transportation:* 45% Coinsurance after Deductible *Air Transportation:* 45% Coinsurance after Deductible
2. Dental Anesthesia and Facility Charges ✸ Coverage is limited to: • A Covered Person who is a child under the age of seven (7) who is determined by two (2) dentists to require necessary dental treatment; or • A Covered Person who is severely disabled; or • A Covered Person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.	20% Coinsurance after Deductible	45% Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
3. Diabetes Services ✸ Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes.	20% Coinsurance after Deductible Copayment/Coinsurance consistent with type of service required.	45% Coinsurance after Deductible
4. Emergency Room Services Physician charges may be applicable, if billed separately. See *Professional Fees for Surgical and Medical Services* below. Copayment/Coinsurance charge will be waived when hospital inpatient or observation admission for the same condition occurs within twenty-four (24) hours.	[$0 - $250 Copayment per visit] [20% Coinsurance after Deductible]	[$0 - $250 Copayment per visit] [45% Coinsurance after Deductible]
5. Hearing Screenings for Newborns	20% Coinsurance after Deductible	45% Coinsurance after Deductible
6. Immunization - Routine Only (Received in Physician's Office)	20% Coinsurance after Deductible for adults over 18 yrs. No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.	45% Coinsurance after Deductible. No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.
7. Inpatient Hospital Services ✸ Semi-Private Room covered.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
8. Maternity Services ✸	*Physician Office*: 20% Coinsurance after Deductible No Copayment applies to Physician office visits for prenatal care after the first visit. *Hospital Outpatient- Observation*: 20% Coinsurance after Deductible per visit *Hospital Inpatient Services*: 20% Coinsurance after Deductible *Outpatient Laboratory services:* 20% Coinsurance after Deductible *Outpatient X-ray/Imaging:* 20% Coinsurance after Deductible	*Physician Office:* 45% Coinsurance after Deductible *Hospital Outpatient- Observation*: 45% Coinsurance after Deductible *Hospital Inpatient Services*: 45% Coinsurance after Deductible *Outpatient Laboratory services:* 45% Coinsurance after Deductible *Outpatient X-ray/Imaging:* 45% Coinsurance after Deductible
9. Newborn Child Coverage ✸	20% Coinsurance after Deductible	45% Coinsurance after Deductible
10. Observation Care ✸ If an Observation admission results in a conversion to an Inpatient Admission, the Observation Copayment will be waived. The alternate Copayment/Coinsurance will apply.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
11. Osteoporosis Services/Bone Mineral Density (BMD) Testing ✸ Diagnosis, treatment, and appropriate management of osteoporosis are covered for persons with a condition or medical history for which bone mass measurement is medically indicated. When these services are performed in a Physician's office, Physician's charges may	*Laboratory Services*: 20% Coinsurance after Deductible *X-ray/Imaging:* 20% Coinsurance after Deductible *Other Diagnostic/Therapeutic Services*: 20% Coinsurance after Deductible	*Laboratory Services*: 45% Coinsurance after Deductible *X-ray/Imaging:* 45% Coinsurance after Deductible *Other Diagnostic/Therapeutic Services*: 45% Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
apply. See *Physician's Office Services* below. A list of osteoporosis services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling our Customer Contact Center at the number listed on Your ID card.		
12. Outpatient Diagnostic Services ✸ Covered health services received on an outpatient basis at a Hospital or Alternate Facility include: • Laboratory services • X-Ray/Imaging • Other diagnostic & therapeutic services When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below. A list of diagnostic/imaging services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling our Customer Contact Center at the number listed on Your ID card.	Laboratory Services (Not performed in a Physician's office): 20% Coinsurance after Deductible Laboratory Services (Performed in a Physician's office): 20% Coinsurance after Deductible X-Ray/Imaging (Not performed in a Physician's office) and all other Diagnostics: 20% Coinsurance after Deductible X-Ray/Imaging (Performed in a Physician's office): 20% Coinsurance after Deductible	Laboratory Services (Not performed in a Physician's office): 45% Coinsurance after Deductible Laboratory Services (Performed in a Physician's office): 45% Coinsurance after Deductible X-Ray/Imaging (Not performed in a Physician's office) and all other Diagnostics: 45% Coinsurance after Deductible X-Ray/Imaging (Performed in a Physician's office): 45% Coinsurance after Deductible
13. Outpatient Surgery/Hospital Procedures ✸ Coverage includes surgical services and hospital procedures received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment. • Surgical Implants Implants for cosmetic or psychological reasons are excluded, see Section 12, M. in Your Policy.	Outpatient Surgery/Hospital Procedures: 20% Coinsurance after Deductible per outpatient surgery or procedure Surgical Implants*:* [Copayment consistent with type of service received]. [20%] [45%] Coinsurance after Deductible]]	45% Coinsurance after Deductible Surgical Implants*:* [Copayment consistent with type of service received]. [45% Coinsurance after Deductible]
14. Physician's Office Services	20% Coinsurance after Deductible No Copayment for immunizations for children from birth to age eighteen (18).	45% Coinsurance after Deductible No Copayment for immunizations for children from birth to age eighteen (18).
15. PKU/Medical Foods and Low Protein Modified Food Products for Metabolic Disorders Please refer to Your Policy Section 11 (Covered Benefits) for limitations.	20% Coinsurance after Deductible	45% Coinsurance after Deductible

✸ Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
16. Preventive Health & Wellness Care Services may be performed in a Physician's office or an outpatient facility and may incur both a professional fee and/or outpatient facility charges. Coinsurance will be consistent with type of service received. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient diagnostic services are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Physician's charges may apply. See *Physician's Office Services* above.	*Cholesterol Tests:* [0% -45%] Coinsurance after Deductible *Colon Screening:* [0% - 45%] Coinsurance after Deductible *Well-Woman:* [0% - 45%] Coinsurance after Deductible *Prostate Exam:* [0% - 45%] Coinsurance after Deductible *PSA test:* [0% - 45%] Coinsurance after Deductible *Diabetes A1C Test:* [0% - 45%] Coinsurance after Deductible *Osteoporosis Services:* [0% - 45%] Coinsurance after Deductible	[Covered In-Network only]
17. Professional Fees for Surgical and Medical Services	20% Coinsurance after Deductible	45% Coinsurance after Deductible
18. Reconstructive Procedures ✸ Please refer to Your Policy Section 11 (Covered Benefits) for limitations.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
19. Rehabilitation Services <u>Outpatient Rehabilitation Therapy</u> Any combination of Network and Non-Network Benefits is limited as follows: ▪ 60 Combined visits per Calendar Year for Physical, Occupational and Speech Therapy ▪ 36 Visits of Pulmonary Rehabilitation Therapy within a 12-week period per [Calendar] [Plan] Year. ▪ 36 Visits of Cardiac Rehabilitation Therapy within a 12-week period per [Calendar] [Plan] Year. <u>Inpatient Rehabilitation Services</u> ✸ Any combination of Network and Non-Network Benefits is limited up to a maximum of [60 – 120] days per [Calendar] [Plan] Year. Rehabilitation Therapy services that are considered maintenance, developmental or educational in nature are not covered Benefits.	<u>Outpatient Rehabilitation Therapy</u> Physical Therapy/Occupational Therapy/Speech Therapy: 20% Coinsurance after Deductible Pulmonary Rehabilitation: 20% Coinsurance after Deductible Cardiac Rehabilitation: 20% Coinsurance after Deductible <u>Inpatient Rehabilitation Services</u> [0% - 45%] Coinsurance after Deductible] [$0 - $5,000] per Inpatient Stay] [$0 - $1,000] Copayment per day] [$0 - $1,000] Copayment per day to a maximum of [$0 - $5,000] Copayment per Inpatient Stay]	<u>Outpatient Rehabilitation Therapy</u> 45% Coinsurance after Deductible <u>Inpatient Rehabilitation Services</u> [0% - 45%] Coinsurance after Deductible
20. Skilled Nursing Facility (SNF) ✸ Any combination of Network and Non-Network Benefits is limited to [60-120] days per Calendar Year.	20% Coinsurance after Deductible	45% Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
21. Urgent Care Center Services Covered Health Services received at an Urgent Care Center that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. If radiology and other diagnostic services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply.	[$0 - $250 Copayment] per visit] [No Copayment] [20% Coinsurance after Deductible]	[$0 - $250 Copayment] per visit] [0% - 45%] Coinsurance after Deductible

OPTIONAL RIDERS		
[Temporomandibular Joint Disorder (TMJ)] [When these services are performed in a Physician's office, Benefits are described under *Physician Office Services* above.] [Coinsurance consistent with applicable inpatient hospital, outpatient, hospital or other services required.]	NETWORK	NON-NETWORK
	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible

✸ **Requires Prior Authorization. Refer to Your Certificate of Coverage for details.**